WELFARE in REVIEW

ICE OF JUVENILE DELINQUENCY AND YOUTH DEVELOPMENT · CUB
AN REFUGEE PROGRAM STAFF · CHILDREN'S BUREAU · BUREAU OF
MILY SERVICES · OFFICE OF AGING · OFFICE OF JUVENILE DELINQUEI
LDREN'S BUREAU · BUREAU OF FAMILY SERVICES · OFFICE OF AGINC
ICE OF JUVENILE DELINQUENCY AND YOUTH DEVELOPMENT · CUB
AN REFUGEE PROGRAM STAFF · CHILDREN'S BUREAU · BUREAU OF
MILY SERVICES · OFFICE OF AGING · OFFICE OF JUVENILE DELINQUE
LDREN'S BUREAU · BUREAU OF FAMILY SERVICES · OFFICE OF AGINC
FICE OF JUVENILE DELINQUENCY AND YOUTH DEVELOPMENT · CUB
BAN REFUGEE PROGRAM STAFF · CHILDREN'S BUREAU · BUREAU OF
MILY SERVICES · OFFICE OF AGING · OFFICE OF JUVENILE DELINQUE
ILDREN'S BUREAU · BUREAU OF FAMILY SERVICES · OFFICE OF AGINC
FFICE OF JUVENILE DELINQUENCY AND YOUTH DEVELOPMENT · CUB
BAN REFUGEE PROGRAM STAFF · CHILDREN'S BUREAU · BUREAU OF
MILY SERVICES · OFFICE OF AGING · OFFICE OF JUVENILE DELINQUE

DOCUMENTS
MICHIGAN STATE UNIVERSITY

FEBRUARY
1965
Vol. 3-No. 2

U. S.
DEPARTMENT
OF HEALTH,
EDUCATION,
AND
WELFARE
Welfare
Administration

U. S.
DEPARTMENT
OF HEALTH,
EDUCATION,
AND WELFARE

Welfare Administration

Children's
Bureau

Bureau of Family
Services

Office of Aging

Office of Juvenile
Delinquency and
Youth Development

Cuban Refugee
Program Staff

WELFARE in REVIEW

Welfare in Review is the official monthly publication of the Welfare Administration. Statements in Review articles do not necessarily reflect official policies of the Welfare Administration.

Welfare in Review is prepared in the Division of Research, Office of the Commissioner, Welfare Administration. Suggestions or comments should be addressed to the Editor, Welfare in Review, Welfare Administration, 330 Independence Avenue, S.W., Washington, D. C. 20201.

Contents of the publication are not copyrighted; any items may be reprinted but citation of Welfare in Review as the source is requested.

Use of funds for printing this publication has been approved by the Director of the Bureau of the Budget July 22, 1963.

Welfare in Review is for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price $3.00 per year; $1 additional for foreign mailing. 35 cents per single copy.

U. S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

ANTHONY J. CELEBREZZE, Secretary

Welfare Administration

ELLEN WINSTON, Commissioner

JOSEPH H. MEYERS, Deputy Commissioner

GENEVIEVE W. CARTER, Director
Division of Research

Volume 3 Number 2

FEBRUARY 1965

In This Issue

Page

Children's Bureau Health Service Activities Under the 1963 Amendments .. 1
Katherine B. Oettinger

New Directions in Aging and Their Research Implications 8
Clark Tibbitts and June L. Shmelzer

Cooperative Research and Demonstration Reports 15

Notes 14
Publications of Interest 19
Program and Operating Statistics 21

Children's Bureau Health Service Activities Under the 1963 Amendments

KATHERINE B. OETTINGER*

A WIDE RANGE of developments are taking place in Children's Bureau health programs as a result of the Maternal and Child Health and Mental Retardation Planning Amendments of 1963. These epoch-making amendments to the Social Security Act became law on October 24, 1963. On February 10, 1964, the money authorized by the new law was made available, and exciting new vistas of action to improve the health of mothers and children were opened up to public health agencies.

The purposes of the 1963 amendments are "to assist States and communities in preventing and combating mental retardation through expansion and improvement of the maternal and child health and crippled children's programs, through provision of prenatal, maternity, and infant care for individuals with conditions associated with child-bearing which may lead to mental retardation, and through planning for comprehensive action to combat mental retardation, and for other purposes."

For Children's Bureau programs this legislation provides for:

1. Over a period of 7 years, doubling the existing $25 million annual authorization for Federal grants for maternal and child health.

2. Doubling, over a period of 7 years, the present $25 million annual authorization for Federal grants for crippled children's services. One-half of the annual increases in the appropriations for maternal and child health and crippled children's programs are to be used for programs for mentally retarded children.

3. A new 5-year program of project grants to assist State and local health departments in developing more effective maternity and infant care programs for women in the high-risk groups who are unable to pay for needed medical care.

4. New authority for the Children's Bureau to make grants and contracts for research related to the maternal and child health and crippled children's programs.

Thus the estimated Federal expenditures for grants under these amendments in fiscal years 1964-68 are:

(in millions)

	1964	1965	1966	1967	1968
Extending authorization:					
Maternal and child health services	$5	$10	$15	$15	$20
Crippled children's services	5	10	15	15	20
New legislation:					
Special project grants for maternity and infant care	5	15	30	30	30
Research projects relating to maternal and child health and crippled children's services	2	3	4	6	8
Total grants	$17	$38	$64	$66	$78

EXPANDED MATERNAL AND CHILD HEALTH ACTIVITIES

The State health departments have been making use of maternal and child health funds since fiscal year 1956 to

* Chief, Children's Bureau. Based on report to the State and Territorial Health Officers at the 1964 Conference of the Surgeon General of the Public Health Service and the Chief of the Children's Bureau, Washington, D.C., November 10, 1964.

establish demonstration services, training, and study projects focused on aspects of prevention, diagnosis and evaluation, health supervision, and problems in the growth and development of retarded children. The 1963 amendments make it possible for State health departments to expand and develop their activities in all of these areas that had proved to be fruitful prior to 1963. By the end of 1964 there were 92 clinics for mentally retarded children which were supported in whole or in part by Children's Bureau funds. Countrywide, there are 128 clinics under various auspices.

During 1963, mental retardation clinics supported by maternal and child health programs served approximately 27,000 mentally retarded children and their families in 47 States. The services provided include diagnosis, evaluation of a child's capacity for growth, the development of a treatment and management plan, interpretation of findings to parents, and follow-up care and supervision. Waiting lists are still far too long. As of December 31, 1963, at least 3,800 children were on such lists.

Of the 27,000 children served, 10,500 were new admissions. Their age distribution was as follows:

Age in years	Percent
Under 1	3.7
1-4	29.2
5-9	45.0
10-14	16.6
15-17	4.2
18-20	1.3
Total	100.0

One-third of the children new to the program were under 5 years of age. This is significant, since an important objective of the clinical programs is to reach children when they are young.

As an important part of the program, fellowships in areas of mental retardation have been increased. During fiscal year 1965 more than 40 such fellowships are being supported by Children's Bureau funds, primarily for pediatricians but also for psychologists and biochemists.

In a field where there is a real lack of trained personnel, the service demonstration projects have also proved their value as training and orientation centers for a variety of professional workers. These projects are serving as a base for the teaching and training of medical students, interns, residents, and nurses and for inservice training for health department personnel and personnel of other State agencies and institutions. Special institutes have reached groups of nurses, clergymen, police officers, nutritionists, social workers, teachers, and others.

A significant use of training funds has been the training of nurses with regard to mental retardation. As of the end of December 1964, five university schools of nursing had presented training projects which had been approved for financial support by the Children's Bureau. In addition, training projects in several other schools of nursing were under consideration.

A number of the projects have been set up to study a particular phase of mental retardation or aspect of service. For example:

1. Study of the services a metropolitan area might need for the mentally retarded and an assessment of how these services can be provided.

2. Evaluation and study of the use of a mobile clinic team to stimulate the development of local clinic services.

3. Study of the pattern of growth and development of infants who are mentally retarded.

4. Field trials and studies of screening methods and techniques for inborn errors of metabolism such as phenylketonuria (PKU).

Almost all projects have undertaken particular studies as a part of carrying out their major functions. A number of training projects have studied attitudes of medical students toward the retarded in order to strengthen the approaches in a teaching program. Other areas studied include dental problems of the retarded child, problems of mental retardation as reported in populations of Indian children living on reservations, waiting lists of children for admission to State institutions, and the growth and developmental

patterns of matched groups of mongoloid children reared at home and in institutions.

Two specific areas in this program where preventive efforts could be applied are being highlighted. The first correlates mental retardation and prematurity. Special projects of maternal and child health programs aimed at providing care for premature infants have pointed up the high incidence of mental retardation in this group and have underlined the great need to prevent prematurity as one way of preventing mental retardation. Other demonstrations and studies have identified the relationship between the rate of prematurity, the amount of prenatal care, and certain conditions during pregnancies that might be considered to be of high risk to health. On this basis the Children's Bureau is intensifying its efforts to assist the States in developing better maternity care, particularly for those groups of women who are considered to run a high risk in their pregnancy.

New Maternity Care Projects

The 1963 amendments provide for a new medical care program for women with complications of pregnancy in an effort to reduce the incidence of prematurity and associated handicaps in the infant. Grants to meet up to 75 percent of the cost of projects for the providing of medical, hospital, and related care for certain prospective mothers are authorized. These are mothers who have conditions associated with child-bearing which increase the hazards to their own or their infant's health and for whom State or local health departments have determined that necessary health care is not available because they are from low-income families or for other reasons beyond their control.

Late in the fiscal year 1964, $5 million was appropriated for this program, and for fiscal year 1965, $15 million has been appropriated. Eleven projects had been approved by the end of calendar year 1964. These programs have been initiated in both rural and urban areas, including Chicago; Detroit; New York City; Baltimore; Minneapolis; Philadelphia; Portland, Ore.; Morgantown, W. Va.; Augusta, Ga., and surrounding counties; and Puerto Rico with two projects. In the urban areas there is a close association between the health departments and teaching hospitals in providing prenatal as well as delivery care. Some health departments are including the provision of prenatal care by maternity nurses under obstetric supervision. Night prenatal clinics are proving successful in some programs. In one section of a large city, the health department has contracted with a group insurance prepayment plan to provide complete care for 600 patients. Some projects include homemaker services and other out-of-hospital assistance.

The statute permits the Children's Bureau to grant the project funds directly to the local health department, with the consent of the State health officer. In three programs the State health officer, after approving the project, did authorize the Children's Bureau to make the grant directly to the local health officer. This is providing an interesting opportunity to gain further experience in the administrative relationships between State and local health departments and an agency of the Federal Government.

Screening for PKU

The screening of newborn infants for metabolic diseases such as phenylketonuria which result in mental retardation is becoming increasingly common, and screening tests that can be done simultaneously for other conditions are showing encouraging promise.

The success of the trials of the Guthrie test for phenylketonuria has greatly stimulated interest in the possibilities of preventing mental retardation due to specific metabolic disorders. The nationwide field trial of the Guthrie screening test was completed in December 1963. The number of newborn infants tested was over 400,000; 39 confirmed cases of phenylketonuria were diagnosed and placed under treatment. This is the first time that such a high number of infants with

this disease were diagnosed so early in life.

The Children's Bureau is now urging all States to have a program for screening infants for phenylketonuria. Four States--Louisiana, Massachusetts, New York, and Rhode Island--have enacted laws making such screening mandatory. Two States--Illinois and Oregon--have enacted permissive legislation. Other States are encouraging hospitals to set up screening programs, and substantial progress is being made in many States. As of October 1964, only seven States had no hospitals doing blood screening. In nine States 90 percent or more of the hospitals were doing blood screening, and in three States from 50 to 90 percent of the hospitals had programs.

EXPANDED CRIPPLED CHILDREN'S PROGRAMS

The increased funds for the crippled children's programs provided by the 1963 amendments included some funds earmarked specifically for mentally retarded children. As a result many States are now able to include more physically handicapped retarded children. One of the uses to which these funds is being put is the development of special programs for children with multiple handicaps. Such a program has been established, for example, in the Children's Rehabilitation Unit at the University of Kansas Medical Center. Two strong features of this center are the excellent speech and hearing services and the integration of special education into a medical setting. Classes for mentally retarded children, for children with a variety of neuromuscular disabilities, and for preschool deaf and hard-of-hearing children, and individual and group therapy for children with delayed speech are among the educational activities conducted at the center in addition to diagnostic, evaluative, treatment, and rehabilitative services by a multiprofessional team. Graduate training is given to physicians, nurses, and students in speech, hearing, special education, social work, and occupational and physical therapy.

With the new funds crippled children's agencies are also taking steps to provide medical and surgical care for physically handicapped children in institutions for the mentally retarded; nine States are beginning to use their grants to provide dental services for handicapped children.

Several factors are influencing development of services for children with speech and hearing problems. For one, there are now new and refined techniques in otologic surgery. Despite the effectiveness of antibiotics, many children need surgical treatment to prevent and repair damage to their ears. This improved surgery has made the term "conservation of hearing" very meaningful.

Another influence on hearing conservation programs is the increased interest of pediatricians and otologists in testing the hearing responses of infants and very young children. This interest in early testing is matched by a growing acceptance of the view that hearing aids can be successfully used by very young children. Recently the Children's Bureau made a grant for a nationwide study of the current practices in the selection and purchasing of hearing aids for children. We expect this study to provide us with the basis for developing better guidelines for the State programs.

Another new use to which some of the crippled children's funds earmarked for mental retardation is being put is in the area of cytogenetic or laboratory services. Project grants have been approved for new programs and extensions of clinical services, at hospitals or medical schools, for chromosome analysis and diagnosis of various medical conditions which may be genetic and which often result in mental retardation. On the basis of the analyses, counseling may be given to parents seeking advice on genetic questions. As of September 1964, 11 such projects had been approved.

NEW RESEARCH GRANTS PROGRAM

The 1963 amendments also authorized grants to public or other nonprofit agencies and organizations engaged in re-

search relating to maternal and child health and crippled children's programs.

A major concern of the Children's Bureau over many years has been the relatively high incidence of infant mortality in this country compared with other industrialized societies. The Bureau estimates that at least 20,000 babies could be saved annually through improved health services. Premature infants have a particularly high infant mortality rate. Furthermore, a high proportion of them fail to develop normally--many become victims of mental retardation, neurological damage, and mental handicaps.

The initial research in this area is focused primarily on an effort to secure findings that can be readily translated into programs--programs that will save lives and reduce the incidence of mental retardation and birth anomalies. To accomplish this objective, the Children's Bureau held a conference of all the 12 schools of public health, bringing together the professors of maternal and child health and crippled children's services as well as biostatisticians and epidemiologists. They are working cooperatively with the Children's Bureau in developing its research programs relating to the critical issues of infant mortality and prematurity.

The Children's Bureau and the schools of public health will concentrate initially on the collection of basic data concerning the community, characteristics of the residents, and health services. These studies will be made in the urban and rural slums where the incidence of infant mortality has been increasing. The material collected will be analyzed to establish target areas with a high incidence of infant mortality, infant morbidity, prematurity, congenital defects, and mental retardation.

These "high-risk, low health-status" communities will then be studied in depth to ascertain the factors related to these conditions. The motivation, capacity, and opportunity for utilization of health services will be examined. This will be counterbalanced by intensive evaluation of the health services available.

The Bureau believes that through such coordinated research under the direction of able scientists, a solid basis can be achieved for local, State, and national action to give every pregnant woman an opportunity for a normal delivery and every infant an opportunity for normal growth and development.

ADVISORY COMMITTEES

In order to make the most effective use of the provisions of the 1963 amendments, the Children's Bureau last spring appointed two special advisory committees. The Maternity and Newborn Advisory Committee advises on maternity care policies, especially in relation to high-risk mothers and their babies. The Technical Committee on Clinical Programs for Mentally Retarded Children provides guidance to the Bureau on mental retardation programs for children. The committees' expert knowledge and guidance are already being utilized by the Bureau in its programs. The committee members include researchers, educators, and practitioners from a variety of professional disciplines in both the medical and social work fields.

THE BATTERED CHILD

The problem of the so-called battered child must concern all of us, but it is of particular urgency for physicians. Although child abuse is most frequently recognized in a medical setting, the causes behind this terrible result are essentially social problems, and satisfactory disposal of such cases often involves hospitals, physicians, social agencies, and the courts.

The proposed language advocated by the Bureau for legislation to protect these children makes mandatory a report by a physician when he has "reasonable cause to suspect" that a child has had "serious physical injury" inflicted upon him by a person responsible for his care.

As of July 1964, 11 States had passed some form of legislation in relation to the battered child. Seven were considering legislation. Of course, the goal must

be protective legislation in every State.

The Children's Bureau's interest is reflected in special demonstration project grants to study the most effective implementation of legislation and to determine the nature of the basic parental problems underlying child abuse. A staff consultant who is both a lawyer and a social worker is available to medical groups and others for consultation on this difficult subject. The Bureau is working in close collaboration with a number of medical groups on this problem. Special advisory groups have been called into the Bureau, and they have made suggestions as to how we can promote a better understanding of this problem among those who touch the lives of children.

THE 1962 AMENDMENTS

The 1962 amendments to the Social Security Act are another example of the Children's Bureau's expanding administrative obligations. These amendments provided for child welfare services in every political subdivision by 1975; for day care services when these are in the best interests of mother and child; and for research, demonstration, and training grants.

In addition to earmarking funds for day care services, the 1962 Public Welfare Amendments required that each State department of public welfare establish a State advisory committee on day care services representing public and voluntary groups in various areas of health, education, and welfare. Active programs are now underway in 46 States.

A good look is being given to all existing day care facilities because the law requires that if Federal funds are used, the facilities must be licensed or must meet the standards of the State licensing authority. Hundreds of hitherto unknown facilities, particularly independent day care centers and family day care homes, have come to light as a result of this requirement. For the first time, we are getting a real picture of the quality of care children are receiving, and it is not entirely bright. We are preparing to make a report to the Nation on this problem--a problem stemming largely from our changing economy in relation to mothers in the labor force--through a National Conference on Day Care to be held in Washington, D.C., in May 1965.

The fact is that while we are making a good start now, the problem has been neglected for too long a time. The need for day care services is growing so rapidly that we are in danger of finding ourselves in the same place no matter how fast we run. In fiscal year 1964, we had $4 million, allocated on a formula basis, with which to help States; for fiscal year 1965, the allocation remains the same. These amounts are very small in relation to the need.

Under the 1962 amendments, nearly all States provide some child welfare services for mentally retarded children, particularly those in their own homes and in foster family care. Public child welfare agencies reach about 29,000 mentally retarded children each year, but few States have the needed range of specialized services for these children. Arkansas, Louisiana, and New Mexico, are reported to have developed small group homes for mentally retarded children. Delaware, California, Utah, Minnesota, and Louisiana have developed some day care services for the mentally retarded child, but these are limited and just getting underway.

The new research, demonstration, and training projects in child welfare are living up to their great promise. Research and demonstration grants cover a wide variety of projects including homemaker service to the mentally retarded, studies of unmarried mothers, and integration of the physically handicapped with normal children in recreational settings. With their training grants, schools of social work are increasing their staff and are providing valuable field instruction experiences for students in child welfare.

In one demonstration project supported by the Children's Bureau through its child welfare research and demonstration program, the District of Columbia

public school system in cooperation with the District Departments of Public Health and Public Welfare is developing a school-centered rehabilitation program for school-age pregnant girls in an effort to encourage them to continue their schooling and to make available the needed health and welfare services. This program is now in its second year.

These girls, but for this program, would have been compelled to become school dropouts since most schools exclude them when their pregnancy becomes known. Judging from past experience, only a few would have returned to classes again after the birth of their babies. After dropping out of school, many would have spent their time aimlessly in meager and deprived homes falling into undesirable, purposeless living patterns and perhaps perpetuating the conditions to which they became victims.

Of course, at this point, we have no final test of the effectiveness of the services. But the small group of girls we have been able to reach see themselves as entering the normal stream of society: they are eager to obtain a public school education and look forward to eventually being wives and mothers in a family setting.

INTERNATIONAL HEALTH RESEARCH

The Children's Bureau has authority for international health research, using United States owned foreign currency in six countries. Since funds are limited we have concentrated on a few areas of study which relate closely to emphases in our own domestic programs--pregnancy and the newborn, congenital defects, and mental retardation.

Two examples show how this program can contribute to improving services for mothers and children in the United States. With the completion of the Guthrie trials in the United States, it became apparent that information on the incidence of phenylketonuria in various ethnic and racial groups would be valuable. To this end, we have developed testing programs in Poland, Yugoslavia, Israel, and Pakistan, and one is now being negotiated with India. Israel will test all newborns for the next 2 years. Biochemists from three of the countries were trained in the Guthrie technique in the United States. Within 2 years, we should have some interesting data on this disorder.

Another example of applied research in other countries which will provide useful answers for our crippled children's program is a study of methods of identifying young infants with hearing defects, using the public health nurse in well-baby clinics for this purpose. Israel, where all infants attend such centers, offers an ideal spot for demonstrating the efficiency or nonefficiency of such a method. A somewhat similar study is underway in Poland.

We may be justly proud of what the Children's Bureau and States together are accomplishing under our expanding legislation. The swiftness of our progress augurs well for the years ahead--for the future of these services and, most of all, for the children served.

New Directions in Aging and Their Research Implications

CLARK TIBBITTS and JUNE L. SHMELZER*

A RECENT book review contains a statement particularly relevant to aging and welfare research. Commenting on a volume of readings in gerontology, the reviewer stated:

> "This new and burgeoning field represents a peculiar amalgam of scientific research and a reformist commitment with the attributes of a major social movement. Gerontology is more than a discipline devoted to understanding aging phenomena and institutional adaptations to varying percentages and problems of the aged; it is also a crusade to help the older person lead a 'full life.'" [1]

The reviewer did not elaborate. Nevertheless, his observation suggests a number of points which are pertinent to the present discussion. First, the umbrella we glibly call "aging" does indeed include both a discipline and a practice. It embraces both a growing body of information about older people and a wide variety of programs, techniques, and institutional forms and adaptations developed in their behalf. Aging thus connotes both action and research which, perhaps not uniquely, have been growing simultaneously.

The second point is the enormous range of subject matter and social action covered by the field. With respect to research alone, the field has been divided into two broad categories--the biological and the social--each of which is divisable into a number of relatively clear-cut areas. Biological gerontology is concerned with normal aging in the human organism, with particular reference to changes in tissue structure and function; in speed, strength, and endurance of the neuromuscular system; and in processes which may hasten normal aging and the long-term diseases and conditions common among older people. Social gerontology is concerned with the alterations in psychological capacities and performances, and with changes in the social characteristics, circumstances, status, and roles of individuals over the second half of the life span; with the nature and processes of adjustment, personality, and mental health in the aging individual; and with the biological processes of aging and changing health status insofar as they influence social capacity and performance in the later years. Social gerontology also seeks to discover the role of the social environment as a determinant of aging and of the behavior and position of older people in society.

Third, it is well-recognized by all who are engaged in the field, and it is inherent in the preceding definition, that many if not most of the problems--whether research or application--with

---

* Dr. Tibbitts is Chief of the Division of Research and Training, Office of Aging. Miss Shmelzer, formerly in the Office of Aging, is now with the Office of Economic Opportunity. This article is adapted from a paper appearing in the Proceedings of the Fifth Biennial Workshop on Public Welfare Research and Statistics, published January 1964 by the Welfare Administration.

[1] A review by Leonard D. Cain, Jr., of "Gerontology, A Book of Readings," by Clyde B. Vedder, in the American Sociological Review, June 1964, pp. 458-459.

which we are dealing require a multidisciplinary approach. None stands out in greater relief, perhaps, than the varied and complex interrelationship of the many factors involved in senescence or in development through the later stages of the life span. Every student of gerontology now recognizes the influence on personality and social behavior of decline in physiological functions and sensory and mental capacities, physical and mental pathologies, alterations in the life situation, and continuous cultural change which often leaves the older person with an outmoded system of values. It is apparent that understanding of the aging process and of retirement and its meaning to the individual involves the integration of data from several disciplines. This is characteristic of many research problems in aging.

In truth, we still know relatively little about the processes of aging, about developmental behavior during the second half of life, and about the impact of older people on the organization and institutions of society. Even the title of this paper, "New Directions in Aging and Their Research Implications," constitutes recognition that most of the programs we have developed for older peole have primarily been guided first, by a set of values more or less generally held and, at present, by these values reinforced with an emerging belief in the necessity for rational social planning.

Quite a number of the programs and services developed for older people appear to be serving their needs, hence to have survived the lack of a supporting, definitive scientific foundation. Gross inventories of rather easily observable characteristics and circumstances of older people coupled with commonsense approaches have enabled us to make important advances, and a social movement is indeed underway.

The demand for scientific bases for action has been steadily growing, however. Federal and local officials along with private entrepeneurs and representatives of voluntary agencies spending many millions of dollars on housing for the elderly are little short of frantic in their demands for knowledge and guiding principles. The entire area of payment for health and medical services is another area in which the demand for data has been steadily increasing.

NEW DIRECTIONS AND RESEARCH AREAS

Current action for aging is taking a variety of courses determined essentially by the major problems of older people and by our knowledge that the process of aging is marked by a series of phenomena which bring physical, psychological, social, and economic problems with consequences for both older people and the nature of the total social fabric. The directions in which we are moving have not, for the most part, been rationally planned. In the sense that they are responses to problems, they have been assigned to us by historical events, changes in the structure and tempo of the society, and by dictates of social conscience. In this sense, there are really no new directions in aging, but rather a gradual recognition and working out of problems, most of which first appeared in the modern Western world and which have shown a recent tendency to grow at geometric rates.

New directions in aging, then, are recent concrete developments and new problem-solving techniques within the major action or "crusade" areas of aging. Research, on the other hand, connotes a variety of methods which are utilized in order to acquire knowledge of the nature, etiology, and consequences of problems and evaluate the efficacy of the solutions devised. Thus defined, research ranges from surveys which collect readily obtainable information to designed experiments which seek definite answers to specific questions.[2] In between these extremes lies a wide variety of fact-

---

[2] Anderson, John E.: Background Paper on Research in Gerontology: Psychological and Social Sciences. Government Printing Office, Washington, D.C., April 1960.

gathering and observational procedures which lead to various levels of understanding.

In this discussion of developing action areas in aging and of research needs that stem from them, we must necessarily be selective. As everyone in the field knows, the action areas are numerous. And as every researcher knows, the opportunities for scientific study within any area are legion.

Housing

Stimulated by the late President Kennedy's message to the Congress in February 1963 which urged more Federal action for this Nation's older people, the Welfare Administration of the Department of Health, Education, and Welfare and the Public Housing Administration of the Housing and Home Finance Agency entered into an agreement of far-reaching significance. In a Memorandum of Understanding signed in October 1963, the two agencies agreed to initiate a program to promote and facilitate both the construction of public housing especially designed for older people and the provision of social, health, recreational, and other services to residents thereof. The aim of the program is to provide housing which will enable low-income older people to meet the special social and health needs which increase with age, to afford privacy and independence, and to extend the period they are able to live comfortably and actively in the community instead of seeking accommodation in the homes of adult children or in institutions.

The implications of this program are vast and exciting. Such evidence as we have indicates that hundreds of thousands of older individuals and couples want and need housing designed for retirement living and available at much less than an economic rent. These older people include large numbers who are essentially well but who, because of meager incomes and unavailability of suitable housing, are living out their days in substandard dwellings or in the homes of adult children, or socially isolated in rooming houses, boarding homes, or hotels. There are thousands of others, afflicted with long-term physical or mental handicaps, who are living in institutions, with relatives, or unsafely in their own dwellings or rooms. It is the belief of the parties to the Memorandum of Understanding that many of these persons in marginal health status can be absorbed into the normal populations of housing projects for older people and that they can live in the projects safely and comfortably, provided essential services are readily available when needed.

Under the agreement, the Public Housing Administration will approve the inclusion of central kitchens and dining rooms, which is an innovation in public housing. The underlying rationale--incidentally, an example of a planning decision not supported directly by research--is that congregate eating will contribute to the health and socialization of residents. The buildings will also afford space--as most housing for older people does now--for an activity center, a lounge, an office for medical and dental examination and consultation, and an office for casework and other kinds of information and counseling services.

Similarly, the agreement contemplates that funds available through the Department of Health, Education, and Welfare will be employed to provide a variety of services in addition to those just mentioned. These may include homemaking and housekeeping help, visiting nurse service, podiatry, payments for drugs and medical services, health education, and assistance in making arrangements for hospitalization and long-term care.

The 1962 Public Welfare Admendments to the Social Security Act have given an enormous boost to States in making these services available. Under this legislation, States that provide for health and welfare services to tenants in public housing in their State welfare plans can receive Federal matching funds paying 75 percent of the cost of such services. In addition, under these amendments, social services can be extended to many older persons who are not receiving old-age assistance.

In a broad sense, of course, explora-

tion of these topics is an integral part of the study of the entire field of housing for older people. It has been estimated that probably one-half of all older households--some 5 million--have special housing needs by reason of low income, restricted activity and mobility, social circumstances, and preferences. The research problems created are numerous, involving at least the fields of architecture, economics, sociology, social psychology, and community planning. A few of the problems needing study are:

At what ages or stages of life do aging people become candidates for special housing?

Is special housing for older people--apartments, hotels, urban clusters, villages--conducive to an increase or decrease in social and community participation, in self-expression and life satisfaction, in health, and in independence?

From the point of view of utilization, of cost, and of isolation of the individual from the community, what services are best provided in facilities located in housing projects? Which can be brought to the residents by outside community agencies? Which can best be provided in outside agency facilities?

What proportions of socially deprived, mildly confused, or physically marginal people can be absorbed in so-called normal housing for the elderly?

What is the financial capacity of older households to pay economic rentals or purchase prices for adequate housing?

Institutions and Other Living Arrangements

A sizable number of older people, now and in the future, will require more highly protected living arrangements and more intensive services than are compatible with housing designed to afford privacy and independence. Residential care facilities such as some homes for the aged, foster homes, and boarding homes; personal care facilities such as many homes for the aged and rest homes; and living with relatives represent a variety of solutions. Long-term care facilities, including chronic disease hospitals and nursing homes, will serve those who require continuing skilled nursing care or psychiatric observation.

OLDER POPULATION IN INSTITUTIONS, APRIL 1, 1960

Type of institution	Number	Rate per 10,000
Total	615,056	371
Mental	177,840	107
Nursing home (skilled)	172,779	104
Public	27,860	17
Private	144,919	88
Nonprofit	45,303	27
Proprietary	99,616	60
Home for aged (domiciliary)	215,174	130
Public	30,108	18
Private	185,066	112
Nonprofit	48,432	29
Proprietary	136,634	83
Other	49,263	30

This whole field and its relationship to the larger field of housing is in flux. A few of the major problems are identified in the questions listed below. They are all questions being faced by our colleagues in welfare programs as well as by workers in other areas.

How many older people are there who require residential care (meals, laundry, maintenance of living quarters, benign oversight); personal care (help with eating, dressing, transferring from bed to chair, managing money) on a continuing basis; or skilled nursing care? What is the rate of turnover within each category?

To what extent is it feasible to provide two or three types of quality care (residential, personal, skilled nursing) within a single institution, as many homes for the aged are now doing? What are the reasons for and the advantages and disadvantages of this practice?

Does the prohibition against payment of old-age assistance to residents of public residential and personal care homes create a gap in community housing and institutional facilities?

What are the advantages and disadvantages to older people of living in foster homes, boarding homes, rooming houses? And what are the advantages and disadvantages to society?

What is happening to older people currently being discharged in large num-

bers from mental hospitals, in regard to their needs, health, satisfaction? What facilities and services are required to provide optimal environments for them?

Welfare Services

The impetus provided by the 1962 Public Welfare Amendments and by the Economic Opportunity Act is remodeling the role of public welfare. Enormous potential lies ahead for improving the environment of older people as we move forward to a role that includes not only financial assistance but also a wide range of social, health, educational, and recreational services.

Imagination, willingness to experiment, and readiness to accept rigorous evaluation are the challenges of the moment. The entire range of inquiry, from rather elementary surveys to meticulously designed research, must be exercised to answer the questions that arise in this field:

What specific services are needed by older people in relation to income, health status and degree of mobility, and living arrangements?

In what ways will recipients of services differ from nonrecipients having similar characteristics and needs?

Will services provided in the home or community really lessen the need for institutionalization?

What are the comparative costs of home services versus institutionalization?

To what extent will various services be utilized only during periods of crisis and to what extent will the need be permanent?

How will the organization and provision of services vary among urban areas with high concentrations of older persons, suburban areas sparsely populated with older persons, and rural areas?

Community Organization

Assignment of responsibility to public welfare agencies for making available a widening variety of services represents merely an extension of the long-time trend toward greater governmental involvement in the promotion of the general welfare. Gradually, over the first two-thirds of this century, the people have invested public agencies with new responsibilities in health services, housing, vocational training and education, employment, rehabilitation, and now social and recreational services for adults. The needs of older people in all of these areas have been brought into sharper focus through surveys, studies, and other assessments of human circumstances and needs.

These developments virtually force public agencies into the planning-coordinating role in the interest of efficiency, in order to maintain program flexibility, and to increase the probability that needs are accurately assessed and met--in other words, to close the gaps of which all of us are well aware and to do it without duplication of effort, unnecessary overlap, and wasteful expenditures of public funds. This area of responsibility is a new one for many, and calls for the guidance of experience and research in answering questions that arise.

What will become the most effective mechanisms for local determination of need, planning for the entire gamut of services, and coordination? What agency of State and local government will be assigned responsibility for, or will be created to perform, these functions?

The welfare amendments authorize State and local welfare agencies to participate in planning and coordination. What specific roles will welfare departments and personnel play in these activities?

How can State and local committees on aging be effective in the promotion of planning, development of services, and coordination?

How can the programs of voluntary secular and church-related organizations serving the needs of specific groups be integrated with total community programs in order to achieve systematic approaches and efficiency in meeting total community needs?

Retirement and Its Uses

Forecasters are stating with increas-

ing confidence that we have only begun to experience the effects of automation and cybernation. Four-fifths of the population 65 years of age and over currently have no attachment to the labor force. There is evidence that this proportion will increase and also that the normal age of retirement will gradually move down to 60 or even less. At the same time, too, the period of vigor and length of life will be further extended.

PERCENT OF POPULATION IN LABOR FORCE, 1890-1964

Year	Men		Women	
	14 years and over	65 years and over	14 years and over	65 years and over
1890	84.3	68.3	18.2	7.6
1900	85.7	63.1	20.0	8.3
1920	84.6	55.6	22.7	7.3
1930	82.1	54.0	23.6	7.3
1940	79.7	42.2	25.7	6.0
1950	79.0	41.4	29.0	7.8
1960	77.4	30.5	34.5	10.3
1964 (Nov.)..	77.5	27.4	37.7	9.9

One of the most challenging areas for action in the field of aging, therefore, becomes that of programing time. Millions of older people are faced with finding ways in which to employ an aggregate of billions of hours of free time. "Doing" is one of the hallmarks of our culture, one of our primary value orientations. Released from the traditional responsibilities of early and middle adulthood, from wage-earning and rearing a family, some older people have the inner resources to develop new interests and to create new places for themselves. The vast majority, however, as at every stage of life, are dependent upon the family the community, and the society to identify for them the tasks which need to be done and to assign them places or roles through which they can contribute to the total welfare and, hence, to their own well-being.

Because of the recognition that there is a tremendous potential residing within our millions of senior citizens and that there are dangers in creating feelings of uselessness among so large a population segment, government at all levels, official and voluntary agencies, and other organized bodies have become involved in creating a variety of programs and projects to involve the older person in some form of activity and therefore in the life of his community and society. These programs and projects generally fall into five major areas--education, citizenship, creative activity, recreation, and volunteer services. We are aware that educational institutions of every kind and a host of other organizations offer older adults educational opportunities in almost every area of knowledge, and that many libraries, for example, have developed special services and programs for older adults. Also, senior citizens, through the civic and political organizations to which they belong, are encouraged to serve on citizens' committees, commissions, and boards, and in other ways participate in community life. There are reported to be over 700 senior activity centers in the country offering opportunities in arts and crafts, education, recreation, and social activities. Approximately 3,000 clubs sponsored by welfare and recreation departments, local chapters of national voluntary organizations, religious groups, and labor organizations offer similar opportunities.

Federally financed demonstration projects and local programs that enable older people to participate in volunteer services have been stimulated by recent developments, such as the successful use of older volunteers in the Peace Corps and by the new antipoverty program.

There is every reason to expect a steady continuation in the trend to provide organized means for senior citizens to make purposeful use of their time. This trend is reflected in the growing number of organized community councils on aging--there are now 838 of them. In the last analysis, this problem of leisure, or retirement, or free time, is directly related to community mental health. For eventually the difficulties of individuals disturb the equanimity of the

whole community. Individual frustration and embitterment born of individual feelings of uselessness and marginality--be they those of juveniles, ethnic groups, or older people--have reverberations on the total community's welfare. The search for uses of retirement is a new confrontation of American society; hence, there are many research areas which must be explored before we can proceed with confidence to extended program development.

Will retirement be a period of shifting personal goals and activities or a prolonged period of withdrawal?

Is disengagement a natural, inevitable process or a function of a culture which has few expectations for older people and limits their resources?

If retired people seek new activities, will appeal be found in creative self-expression, education, voluntary service, recreation, spectator activities? What are the variations by age, sex, physical status, education, social class, income?

Is voluntary community service a practical role for retired people? Are retirees interested? Will agencies use older people? What conditions must obtain, such as nature of service and payment of expenses?

What other functions can senior activity centers serve in addition to leisure-time programs? Could they also provide such services as counseling, information-referral, health education and screening, or retirement preparation?

CONCLUSION

It is apparent that the problems in need of scientific investigation are numerous. Many of the questions raised in the preceding sections can be studied by welfare agencies themselves. Others may be better handled by investigators in colleges and universities, who show growing interest in the field of aging. Nor should the many possibilities be ignored for cooperative arrangements between public and voluntary welfare agencies and institutions of higher learning in carrying out research and demonstration projects.

Work Experience and Training Projects

Guidelines for the work experience and training projects authorized under Title V of the Economic Opportunity Act were transmitted to the State public welfare agencies in December 1964. These pilot or demonstration projects are intended to enlarge the employment opportunities of unemployed fathers and other needy persons by providing constructive work experience, vocational instruction, and basic education, as needed to improve employability. The projects may also include pertinent social services, medical care, and financial assistance necessary in order to enable needy persons to participate in the projects.

Up to 100 percent Federal financing is available. Project approval will be granted for up to 1 year at a time with renewal for additional periods if desirable. Projects will be administered by the State public welfare agency or carried out under its supervision. States will presumably incorporate into their regular public welfare programs those parts of the projects that prove to be successful. In addition, it is hoped that States which have not developed programs for unemployed parents of families receiving aid to families with dependent children will do so as a result of carrying out a Title V project.

Applications for establishing work experience and training projects must be submitted through the State public welfare agency to the Bureau of Family Services, Welfare Administration, Washington, D.C. 20201.

Cooperative Research and Demonstration Reports*

EFFECT OF TERMINATING THE GENERAL ASSISTANCE PROGRAM IN A RURAL COUNTY

In April 1961 after voters had rejected a local tax levy for welfare, Clermont County, Ohio, was virtually forced to discontinue general assistance. As a result of the cut, 129 cases in need as determined by the public welfare department's standards were thrown on their own resources. For 33 additional cases, withdrawal of aid was part of the normal turnover in caseload.

What happened to the members of these 129 families with no visible means of support? How did they manage? What were their health needs? What happened to the children in these families? These were some of the questions that were investigated under a grant from the Cooperative Research and Demonstration Grants Program to the Community Health and Welfare Council of Cincinnati with William P. Walton as project director.

The study showed that because of the termination of general assistance, the lives of the needy were made more difficult and strained. The burden for their support did not disappear, but merely shifted to various churches, voluntary agencies, commercial and civic organizations, local merchants, individuals, and federally assisted programs.

By November 1962, when the research began, 49 families had been shifted to Federal-State categorical assistance, mostly to AFDC. Interviews were conducted with 69 of the 70 families who remained in the community.

The principal findings of the study are:

1. The people included in the study were, for the most part, long-time or native-born residents of the county, relatively young, white, primarily in family groups with a large number of children, and they had not been dependent on public assistance for long periods of time.

2. In some form, the community is still paying for the support of most of these cases. The burden, however, has shifted from public resources to landlords, grocers, physicians, churches, civic groups, voluntary agencies, schools, and individuals, including friends and relatives. There was, for instance, a 54 percent increase in money owed by these persons to landlords, grocers, physicians, and hospitals during the 15-month period.

3. Curtailment of general assistance payments, limited as they were, made the lives of the persons affected more difficult and strained. Despite a variety of community efforts to cushion the shock of the withdrawal of support, there was never enough to meet needs adequately. Anxiety and tension among the affected families increased; circumstances for most became worse. People went hungry, did not always receive needed medical care, and moved into poorer housing.

4. The composition of the family and the presence of children made important differences in how these individuals were able to manage. Parents of school children faced hardships in providing clothing (especially shoes), lunch, and money for school supplies. Childless couples evoked little community sympathy. If they were unable to qualify for federally supported programs, they were forced to live under extremely arduous circumstances, waiting for the time when one or both would be eligible for old-age assistance.

5. The cost of medical care and the health resources available were a prime concern of the people removed from general assistance. They were reluctant to go to physicians unless absolutely

*Based on reports from projects aided by the Cooperative Research and Demonstration Grants Program administered by the Welfare Administration with the cooperation of the Social Security Administration. Requests for additional information on these studies should be directed to the project investigators.

necessary. In 54 of the 69 interviews, health problems were cited as the greatest concern.

6. Mothers went without pre- and post-natal care. Babies were born at home without medical attendance, and mothers and babies received no post-natal care.

7. There was a dangerous lack of protection against preventable disease. Of the 250 children in the families studied, only 18 received all of their smallpox, diptheria, pertussis, and tetanus immunizations and only 15 had received all of the polio immunizations. These children were susceptible to any outbreak of these diseases, which are far more expensive to treat than to prevent.

8. Schools were faced with problems of children who had many unmet medical, material, and personal needs. School principals voiced a desire for an agency capable of dealing firmly with the family situation. They recognized that the unmet needs of the child affect his ability to benefit from educational programs. School officials gave the impression that they would work closely with strong "reaching out" family services.

9. The health records which were studied tended to contradict the stereotype of the relief client as a lazy individual, content to live as a welfare recipient. Rather, these records show a tense, anxious person struggling to manage at a low, unsatisfactory level, whether or not he is receiving assistance payments.

In more than half of the cases, mental and physical handicaps limited the employability of the chief wage earner. Nevertheless, these persons attempted to find employment. One father walked 15 miles from one township to another trying to find work.

10. Outstanding in the analysis of the employment situation of the families studied was the lack of vocational skill and limited educational background of family members.

11. Stopping general assistance could not force the people affected to become self-sufficient. Needs continued, and means that were often difficult and destructive to the individuals involved were found to meet these needs. Families scraped along from one crisis to the next.

12. On the basis of the available data, 49 cases had a good or fair potential for independence.

The investigators suggest numerous ways in which these and other marginal families could be helped to prevent further deterioration and move toward independence. Suggested programs include retraining for unemployed family head, outpatient mental clinics, group and individual casework counseling with a "reaching out" philosophy, adult literacy programs, vocational counseling, guidance and training in the public schools, a program for identifying and working with the school dropout, and improved accessibility to health services, surplus commodities, and other resources, possibly using volunteer transportation.

--Division of Research,
Welfare Administration

INTERCOUNTRY SOCIAL WELFARE SERVICES

Approximately 2 million Americans now live and work in countries outside the United States. Close to 3 million other Americans travel yearly to foreign countries as tourists or businessmen. Almost a million foreign tourists visit this country annually and more than 300,000 are admitted each year as immigrants. With movement of these numbers of persons, problems familiar to local health and welfare agencies in any community, such as adoption; care, custody, and paternity of children; marital conflict; separation, divorce, desertion; and serious illness are now compounded by distance, cultural differences, and national boundaries. Ways in which intercountry social welfare services are provided and some current difficulties encountered in providing such services were the subjects of an investigation undertaken by Dr. Kenneth Murase of the Co-

lumbia University School of Social Work under a grant from the Cooperative Research and Demonstration Grants Program.

Six major service areas were studied: (1) intercountry adoptions, (2) unmarried mothers abroad, (3) repatriation, (4) overseas beneficiaries of governmental programs, (5) immigration services, and (6) the Cuban Refugee Program. Problems and issues pertaining to each area were defined from a reading of case records and interviews with agency representatives, and proposals were made for the improvement of service in each of the areas.

Intercountry Adoptions

Since the end of World War II, more than 30,000 children from foreign countries have been adopted by American families. A serious deterrent to intercountry adoptions has been the lack of both national and international agreement upon the type of protection needed to safeguard the interests of the child and of the prospective adoptive parents. A major step in the direction of facilitating intercountry adoptions would be an international agreement upon a convention which would set forth minimum principles and standards with respect to laws governing adoption. State adoption laws must be strengthened in order to provide for (1) maximum protection to the child and parents, (2) mandatory social studies prior to judicial disposition of an adoption petition, (3) a period of supervised residence of the child in the adoptive home, (4) confidentiality of adoption records, (5) clarification of requirements for termination of parental rights, and (6) specification of the meaning of such terms as "abandonment," "dependency," "neglect," and "legally free for adoption."

The Unmarried Mother and Child Abroad

An increasingly serious situation is the plight of the unmarried mother and child away from home in a foreign country. In most countries, if the woman is destitute, resources are extremely limited and the only alternative is repatriation. The pregnant girl or unmarried mother is likely to be in serious need of counseling but skilled professional help in such situations is usually not available through official channels. One approach is suggested by the experience of the European Common Market in providing reciprocal health and welfare services to citizens of member countries. Consideration should be given to the conclusion of similar agreements to be entered into by the United States government with other governments for the provision of reciprocal services to their respective nationals. International agreement is also needed upon laws pertaining to the civil status and rights of illegitimate children and their mothers; questions of legitimacy and paternity; support; and other related matters affecting the welfare of the unmarried mother and her child.

Repatriation

American citizens and dependents may be returned to the United States from abroad for reasons of destitution, illness, war, and other crises. The Department of Health, Education, and Welfare through State and local departments of public welfare, provides assistance to the repatriate upon his arrival, through (1) reception at the port of entry, (2) emergency financial assistance, (3) social study to determine social and medical needs and resources, (4) resettlement planning, (5) transportation arrangements, and (6) referral to employment, retraining, vocational rehabilitation, medical, and related services. There is no provision, however, for assistance to repatriates while they are still in another country awaiting repatriation. The repatriate destitute in a foreign country is usually desperately in need not only of emergency financial assistance but also legal representation, medical care, assistance in making travel arrangements, and shelter. There is need, therefore, for services abroad in the pre-repatriation period

comparable to the services available to the repatriate upon his arrival in this country.

Overseas Beneficiaries

Currently more than 135,000 beneficiaries of the Social Security Administration and 130,000 beneficiaries of the Veterans Administration (including noncitizens) are living abroad. It is of special concern to these agencies that the benefits are being received by legitimate beneficiaries and that they are being used for the purposes intended. When questions arise as to the legitimacy of a beneficiary or the possible misuse of benefits, an objective appraisal of the situation becomes necessary. In most instances the nearest State Department official is sought to make an investigation. He may be unequipped to render this professional service or may be unable to perform such functions adequately because of the pressure of other duties. In such cases an intercountry service agency may be helpful in providing skilled professional services.

Immigration Services

For the year ending June 1963, some 300,000 immigrants were admitted to the United States. While there is need for expansion of immigration services generally, the focus of attention should be directed to improvement in pre-migration services, such as orientation, language training, vocational training and retraining, employment counseling, and related services to prepare immigrants for resettlement in a new country.

Cuban Refugee Program

The Cuban Refugee Program affords a significant example of public-voluntary partnership in the field of social welfare. Of special significance has been the experience of voluntary agencies in mobilizing local community support for the sponsorship of refugees, and the development of closer liaison at the local level among the various church-related agencies, and between public and voluntary agencies and church-related agencies. Not the least significant are the implications of the Cuban Refugee Program for the vast problem of internal migration within the United States. Changing labor market conditions and manpower needs due to technological developments and economic transitions are generating massive dislocations of the population. In relation to health, educational, and welfare problems attendant upon such population shifts, the experience of the Cuban Refugee Program may provide useful insights and guidelines.

Division of Research,
Welfare Administration

Publications of Interest*

WELFARE ADMINISTRATION

SOCIAL WELFARE IN A CHANGING WORLD: The Place of Social Welfare in the Process of Development. By Elizabeth Wickenden. Welfare Administration Publication No. 8. 1965. 51 pp. Focuses on the idea that the development of social welfare institutions is an integral part of the total developmental pattern of societies. Cities six specific ways in which social welfare contributes to the processes which produce development.

HOMEMAKER SERVICE IN PUBLIC WELFARE: THE NORTH CAROLINA EXPERIENCE. Prepared by North Carolina Department of Public Welfare. Revised ed. Bureau of Family Services, 1965. 43 pp. Originally published in 1961, this pamphlet has been revised to reflect changes in the North Carolina program during the past 3 years. This program has demonstrated how public assistance and child welfare programs, personnel, and funds may be used to develop homemaker service for a broad range of clients in a variety of situations.

WORK EXPERIENCE PROGRAM. Bureau of Family Services, 1965. 12 pp. Briefly describes the program authorized by Title V of the Economic Opportunity Act of 1964. Answers basic questions that citizens may have, particularly in regard to how their community might develop projects to train and educate needy persons.

FOR FUTURE SOCIAL SECURITY BENEFITS: Some Ways That Workers in Local Public Welfare Agencies Can Assure Their Clients' Eligibility. Bureau of Family Services, 1965. 4 pp. How people can be helped to receive full credit for their working years toward future social security benefits.

NINOS CARENTES DE CUIDADOS. (Children and Neglect). By Claire Hancock. Bureau of Family Services, 1965. 61 pp. 25 cents. Spanish translation of a booklet originally published in 1963. Intended to help welfare workers identify situations which constitute such serious neglect that agency or court action is required to remove the danger to the child.

BUREAU OF FAMILY SERVICES PUBLICATIONS, FALL 1964. The leaflets, booklets, reports, and articles now available.

HEALTH OF CHILDREN OF SCHOOL AGE. Children's Bureau Publication 427. 1964. 31 pp. 25 cents. Reports on the many needs in health care provided to children, particularly in the great cities and in low-income families.

HISTORICAL PERSPECTIVE ON MENTAL RETARDATION DURING THE DECADE 1954-1964: A Compilation of Articles in Children. Children's Bureau Publication 426. 1964. 314 pp. $1.75. Articles on mental retardation that have appeared in the periodical, against a backdrop of the development of services in the Bureau and the effect of the 1963 amendments.

A SELECTED BIBLIOGRAPHY ON JUVENILE DELINQUENCY. Children's Bureau, 1964. Revised ed. 72 pp.

OTHER PUBLICATIONS

LEGISLATIVE ACHIEVEMENTS AND ACTIVITIES, 1964. Report to Secretary Celebrezze. By Wilbur J. Cohen, Assistant Secretary (for Legislation), U.S. Department of Health, Education, and Welfare. October 1964. 51 pp. Description and legislative histories of legislation in health, education, and welfare during 1964.

FEDERAL AGENCIES FINANCING RESEARCH, 1964-65. Social Legislation Information Service, Washington, D.C., 1964. 34 pp. $2. A guide to help organizations and individuals who are planning research projects locate the Federal agencies most likely to provide financial assistance.

METHOD AND MEASUREMENT IN SOCIOLOGY. By Aaron V. Cicourel. Free Press, London, 1964. 247 pp. $6.95.

FIRST, THEY MUST READ: A Study to Determine the Literacy Level of Able-Bodied Persons Receiving Public Assistance in East St. Louis, Ill. Prepared under the direction of Deton J. Brooks, Jr. Cook County Department of Public Aid, Chicago, Ill., 1964. 198 pp. Findings indicate an extremely high incidence of functional illiteracy, as did the comparable study conducted in Chicago's Woodlawn area.

*U.S. Government publications for which prices are listed may be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (25 percent discount on lots of 100 or more). Inquiries or orders for other publications should be directed to the publisher or issuing agency.

INSTITUTION OR FOSTER FAMILY: A CENTURY OF DEBATE. By Martin Wolins and Irving Piliavin. Child Welfare League of America, New York, 1964. 62 pp. $1.50. Traces the course of the professional arguments on this issue since 1855. Includes a review of trends as revealed in the statistics on children in foster care and institutional programs and an extensive bibliography.

"Six Views of Youth's Future," AMERICAN CHILD, vol 46, no. 4, November 1964. 50 cents. Papers presented at the symposium, "Manpower Policies for Youth," sponsored by the National Committee on Employment of Youth. Nat Hentoff, Charles E. Silberman, Ivan Berg, Ben B. Seligman, Daniel P. Moynihan, Robert L. Heilbroner give their views.

STREETCORNER RESEARCH: AN EXPERIMENTAL APPROACH TO JUVENILE DELINQUENCY. By Ralph Schwitzgebel. Harvard University Press, Cambridge, Mass., 1964. 163 pp. $3.95. Severely delinquent adolescents are used in the project as experimental subjects.

DELINQUENCY, CRIME AND DIFFERENTIAL ASSOCIATION. By Donald R. Cressey. Martinus Nijhoff, The Hague, 1964. 167 pp. $5.30. About the late Edwin H. Sutherland's criminological theory.

DELINQUENCY AND DRIFT. By David Matza. John Wiley and Sons, New York, 1964. 199 pp. $4.50. How young persons may subscribe to the legal order but nonetheless violate it.

PRIVATE PRACTICE IN SOCIAL CASEWORK. A PROFESSION'S CHANGING PATTERN. By Sidney Levenstein. Columbia University Press, 1964. 234 pp. $6.75. Traces development of private practice in social casework from beginning to present.

MARRIAGE AND YOU: A SOCIOLOGICAL STUDY OF AMERICAN MARRIAGE AND FAMILY LIFE. By Bernard J. Oliver, Jr. College and University Press, New Haven, Conn., 1964. 328 pp. $6.

RELATIONS OF DEVELOPMENT AND AGING. Compiled and edited by James E. Birren. Charles C. Thomas, Springfield, Ill., 1964. 296 pp. $6.75. Papers presented at the 1962 meeting of the Gerontological Society.

ON GROWING OLDER. President's Council on Aging, 1964. 146 pp. 50 cents. Written to help older people understand the aging process and cope with its particular problems.

COMMUNITY MENTAL HEALTH JOURNAL. A new quarterly, with first issue in March 1965. Address: 12 Dimmock St., Quincy, Mass. $10 per year. The board of editors: Sheldon R. Roen, Erich Lindemann, Lenin A. Baler, and Saul Cooper. The Journal will contain articles on research and evaluation, program developments, and theoretical views.

SOCIAL STRUCTURE AND PERSONALITY. By Talcott Parsons, Free Press, London, 1964. 376 pp. $8.50. Collection of essays.

A SOCIAL PSYCHOLOGY OF GROUP PROCESSES FOR DECISION-MAKING. By Barry E. Collins and Harold Guetzkon. John Wiley and Sons, New York, 1964. 254 pp. $6.25.

LET IN THE SUN. By Woody Klein. Macmillan, New York, 1964. 297 pp. $5.95. Tenement life in New York City.

SOCIAL INSURANCE AND ALLIED PROGRAMS. By Robert J. Myers. Richard D. Irwin, Inc., Homewood, Ill., 1965. 258 pp. $6.50. Covers the development, basic principles, structure, and methods of the OASDI system and related programs. Includes the public assistance programs before and after the Social Security Act and the interrelationship between public assistance and social insurance programs.

SOCIAL SECURITY AND SOCIAL SERVICES IN FRANCE. By Alvin L. Schorr. Social Security Administration, 1965. Research Report No. 7. 48 pp. 35 cents. Includes analysis of underlying ideas and attitudes, structure, organization, trends.

SOCIAL SECURITY IN AMERICA. By William Lloyd Mitchell. Robert B. Luce, Inc., Washington, D.C. 79 pp. $1.95. Concise survey of the system under which the author includes social insurance, public assistance, and related social services.

AMERICAN INTERGOVERNMENTAL RELATIONS: THEIR ORIGINS, HISTORICAL DEVELOPMENT, AND CURRENT STATUS. By W. Brooke Graves. Scribner's, New York, 1964. 984 pp. $13.95.

Correction

Statistical Supplement, 1964 edition: On page 7, the columns headed "AFDC," "AB," and "APTD" should be changed to "AB," "APTD," and "AFDC" respectively.

Program and Operating Statistics

PUBLIC ASSISTANCE IN NOVEMBER 1964

About 7.8 million persons were aided under the six public assistance programs[1] in November. The number was roughly 32,000 more than that in October, largely because of the seasonally influenced increases of 20,400 (0.5 percent) in aid to families with dependent children (AFDC) and 12,800 (1.9 percent) in general assistance. Three out of every five States reported higher recipient loads in these programs.

There was an increase of 2,700 or 0.5 percent in the number of recipients of aid to the permanently and totally disabled, and the number of recipients of old-age assistance rose slightly. California contributed substantially to the national rises in the above-mentioned four programs. For that State the increases in number of recipients for these programs ranged from 1,200 in aid to the permanently and totally disabled to 9,600 in AFDC.

In aid to the blind the downward movement in the number of recipients continued, and payments under medical assistance for the aged were made in behalf of 217,300 persons--3,400 fewer than in October.

Total payments, including vendor payments for medical care, amounted to $428.4 million in November--$5.7 million less than in October. The decline centered largely in vendor payments for medical care under federally aided programs in New York (a drop of $2.7 million) and in Pennsylvania (a decrease of $2.9 million). Nationally, money payments for all programs combined rose $678,000, reflecting the increases of $961,000 in AFDC and $247,000 in aid to the permanently and totally disabled.

From October to November the average money payment per recipient declined about $1 in general assistance, and changed by a few cents in other programs. Most of the States reported small changes in average money payments.

Colorado discontinued the reduction in rental allowances for families receiving AFDC (rental allowances had been limited to 72 percent of the State's standard); the average payment per family rose $3.60. Rhode Island initiated a program for medical assistance for the aged and received and approved applications, but did not make any payments during November. There are now 42 States and other jurisdictions with programs of medical assistance for the aged in operation.

---

[1] Data for specified types of assistance under State programs for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged are classified with data for separate State programs for old-age assistance, aid to the blind, aid to the permanently and totally disabled, or medical assistance for the aged.

Table 1. Number of recipients of public assistance in the United States, by month, November 1963-November 1964 1/

[Except for general assistance, includes cases receiving only vendor payments for medical care]

Year and month	Old-age assistance 2/	Medical assistance for the aged 2/	Aid to the blind 2/	Aid to the permanently and totally disabled 2/	Aid to families with dependent children			General assistance 4/	
					Families	Total recipients 3/	Children	Cases	Recipients
	Number of recipients								
1963									
November	2,194,387	152,872	97,843	477,464	955,343	3,921,560	2,946,317	322,000	764,000
December	2,193,581	149,880	97,793	479,312	966,779	3,980,667	2,987,197	352,000	872,000
1964									
January	2,190,006	156,788	97,709	482,432	983,071	4,060,209	3,042,643	376,000	951,000
February	2,188,506	160,471	97,617	486,286	999,970	4,141,730	3,098,336	374,000	933,000
March	2,188,610	172,736	97,760	490,156	1,013,313	4,206,817	3,148,698	374,000	914,000
April	2,186,711	176,416	97,631	493,974	1,023,504	4,261,988	3,188,192	360,000	845,000
May	2,185,137	181,056	97,582	497,451	1,021,647	4,253,591	3,183,965	335,000	746,000
June	2,181,957	187,141	97,409	501,429	1,014,139	4,214,901	3,159,474	325,000	707,000
July	2,177,085	185,641	97,259	508,902	1,009,211	4,191,264	3,142,843	321,000	700,000
August	2,167,687	207,383	97,064	511,565	1,006,106	4,176,778	3,133,162	323,000	712,000
September	2,162,397	208,354	96,852	514,942	1,001,470	4,157,571	3,121,838	321,000	702,000
October	2,160,922	220,783	96,586	519,070	1,005,880	4,174,728	3,138,039	319,000	691,000
November	2,161,464	217,336	96,416	521,789	1,010,016	4,195,113	3,152,468	322,000	703,000
	Percentage change from previous month								
1963									
November	-0.1	-2.7	-0.3	+0.4	+0.1	+0.3	+0.3	-1.5	-0.2
December	(5/)	-2.0	-.1	+.4	+1.2	+1.5	+1.4	+9.6	+14.1
1964									
January	-.2	+4.6	-.1	+.6	+1.7	+2.0	+1.9	+6.6	+9.1
February	-.1	+2.3	-.1	+.8	+1.7	+2.0	+1.8	-.6	-1.9
March	(6/)	+7.6	+.1	+.8	+1.3	+1.6	+1.6	(5/)	-2.1
April	-.1	+2.1	-.1	+.8	+1.0	+1.3	+1.3	-3.7	-7.6
May	-.1	+2.6	-.1	+.7	-.2	(5/)	-.1	-6.9	-11.6
June	-.1	+3.4	-.2	+.8	-.7	-.9	-.8	-3.1	-5.3
July	-.2	-.8	-.2	+1.5	-.5	-.6	-.5	-1.2	-1.0
August	-.4	+11.7	-.2	+.5	-.3	-.3	-.3	+.6	+1.7
September	-.2	+.5	-.2	+.7	-.5	-.5	-.4	-.7	-1.4
October	-.1	+6.0	-.3	+.8	+.4	+.4	+.5	-.7	-1.5
November	(6/)	-1.6	-.2	+.5	+.4	+.5	+.5	+1.2	+1.9

1/ All data subject to revision. 2/ Represents data for recipients of the specified type of assistance under separate State programs and under State programs for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 3/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 4/ Partly estimated. Excludes Idaho, Indiana, and Nebraska; data not available. 5/ Decrease of less than 0.05 percent. 6/ Increase of less than 0.05 percent.

Table 2. Amount of public assistance payments in the United States, by month, November 1963-November 1964 1/

[Except for general assistance, includes vendor payments for medical care]

Year and month	Total 2/	Old-age assistance 3/	Medical assistance for the aged 3/	Aid to the blind 3/	Aid to the permanently and totally disabled 3/	Aid to families with dependent children	General assistance 4/
	Amount of assistance						
1963							
November	$393,517,000	$168,016,542	$28,965,741	$7,990,500	$35,943,652	$122,803,458	$21,209,000
December	402,511,000	168,983,570	30,212,494	8,021,573	36,301,752	126,646,605	23,951,000
1964							
January	407,261,000	168,976,922	30,929,251	8,013,048	36,599,229	128,916,121	25,665,000
February	414,664,000	171,345,730	31,757,790	8,076,895	37,336,550	132,718,951	24,988,000
March	424,754,000	172,520,773	34,679,610	8,140,935	38,241,308	136,836,208	25,155,000
April	427,748,000	171,440,998	36,532,021	8,167,521	38,683,146	139,562,947	24,063,000
May	422,742,000	171,192,802	35,219,429	8,200,759	38,975,943	138,444,208	21,830,000
June	422,689,000	171,148,145	36,836,751	8,190,942	39,359,870	137,029,371	20,985,000
July	423,375,000	171,666,945	36,264,602	8,218,116	40,135,587	137,361,814	21,082,000
August	422,206,000	168,137,446	39,228,542	8,198,173	39,874,445	136,270,573	20,925,000
September	423,675,000	168,530,628	38,264,547	8,179,617	40,476,692	137,659,015	21,237,000
October	434,066,000	170,461,904	43,739,320	8,237,431	41,281,891	139,484,356	21,674,000
November	428,358,000	168,958,005	39,963,969	8,194,036	41,291,845	139,295,652	21,389,000
	Percentage change from previous month						
1963							
November	-1.5	-0.9	-9.1	-1.5	-0.9	-0.5	-2.4
December	+2.3	+.6	+4.3	+.4	+1.0	+3.1	+12.9
1964							
January	+1.2	(5/)	+2.4	-.1	+.8	+1.8	+7.2
February	+1.8	+1.4	+2.7	+.8	+2.0	+2.9	-2.6
March	+2.4	+.7	+9.2	+.8	+2.4	+3.1	+.7
April	+.7	-.6	+5.3	+.3	+1.2	+2.0	-4.3
May	-1.2	-.1	-3.6	+.4	+.8	-.8	-9.3
June	(5/)	(5/)	+4.6	-.1	+1.0	-1.0	-3.9
July	+.2	+.3	-1.6	+.3	+2.0	+.2	+.5
August	-.3	-2.0	+8.2	-.2	-.7	-.8	-.7
September	+.3	+.2	-2.5	-.2	+1.5	+1.0	+1.5
October	+2.5	+1.1	+14.3	+.7	+2.0	+1.3	+2.1
November	-1.3	-.9	-8.6	-.5	(6/)	-.1	-1.3

1/ All data subject to revision. 2/ Total exceeds sum of columns because of inclusion of vendor payments for medical care from general assistance funds and from special medical funds; data for such expenditures partly estimated for some States. 3/ Represents data for payments to recipients of the specified type of assistance under separate State programs and under State programs for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 4/ Partly estimated. Excludes Idaho, Indiana, and Nebraska; data not available. 5/ Decrease of less than 0.05 percent. 6/ Increase of less than 0.05 percent.

Table 3. Old-age assistance: Recipients and payments to recipients, by State, November 1964 1/

[Includes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	October 1964 in--		November 1963 in--	
				Number	Amount	Number	Amount
Total 2/	2,161,464	$168,958,005	$78.17	(3/)	-0.9	-1.5	+0.6
Ala.	111,222	7,511,680	67.54	+0.1	-.9	+2.5	+2.1
Alaska 4/	1,365	5/ 136,234	99.81	-.7	+20.9	-1.5	+24.1
Ariz.	13,286	837,435	63.03	-.2	-.5	-1.0	+.6
Ark.	58,877	3,725,021	63.27	+.1	-1.5	+2.1	+5.4
Calif.	273,242	29,573,806	108.23	+.6	-1.3	+2.5	+5.9
Colo 2/	44,659	4,160,127	93.15	-.1	+.4	-9.5	-17.8
Conn.	7,208	555,019	77.00	-1.9	-11.5	-13.5	-20.8
Del.	1,372	95,781	69.81	+1.6	+6.4	+18.4	+32.7
D. C.	2,402	200,502	83.47	(6/)	+1.6	-3.9	-9.8
Fla. 4/	73,197	4,932,707	67.39	+.3	+1.3	+2.9	+9.0
Ga.	92,296	5,204,344	56.39	(3/)	+.7	(6/)	+2.6
Guam 7/	159	5,629	35.40	---	---	---	---
Hawaii 4/	1,171	87,023	74.32	+.5	+2.9	+3.5	+20.7
Idaho	4,474	325,913	72.85	-.4	+1.1	-10.4	-7.5
Ill. 4/	56,860	5,328,045	93.70	-.3	-1.0	-6.9	+3.7
Ind.	22,857	1,865,307	81.61	-.8	-1.0	-3.1	+3.5
Iowa	27,797	2,589,837	93.17	-.6	+.3	-5.9	-1.7
Kans.	21,751	1,935,538	88.99	-1.0	-6.7	-10.0	-12.5
Ky. 4/	57,520	3,423,290	59.51	+.3	+.8	+3.8	+3.0
La.	130,932	11,123,726	84.96	+.2	(6/)	+1.0	+5.7
Maine 4/	11,092	918,227	82.78	+.1	(6/)	-1.4	-2.7
Md. 4/	9,837	716,611	72.85	+.1	(3/)	+4.1	+5.5
Mass.	53,653	4,791,575	89.31	(3/)	-1.4	-3.6	-5.8
Mich.	49,384	4,564,725	92.43	-.2	-.1	-2.2	+12.7
Minn.	32,845	2,851,790	86.83	-.3	+2.7	-24.2	-39.0
Miss.	73,534	2,868,063	39.00	-.2	-.5	-3.2	-2.3
Mo.	102,800	7,004,535	68.14	-.1	+.6	-1.9	+2.1
Mont.	5,321	381,820	71.76	-.1	-.6	-6.6	-1.6
Nebr.	12,525	1,132,359	90.41	(3/)	-2.4	-1.5	+7.5
Nev.	2,619	234,678	89.61	0	-.1	+1.9	+3.8
N. H.	4,447	457,724	102.93	+.2	+.2	-3.0	-1.6
N. J.	13,872	1,127,088	81.25	-.1	+.1	-1.7	-.3
N. Mex. 4/	10,678	847,668	79.38	-.7	-.6	-1.8	-1.5
N. Y.	56,261	5,338,770	94.89	-.2	-1.4	0	+7.5
N. C.	42,954	2,560,934	59.62	-.8	-2.9	-2.6	+1.4
N. Dak. 4/	5,257	465,616	88.57	-.6	-2.2	-6.2	-7.3
Ohio	83,127	7,154,847	86.07	-.1	-.3	-2.0	-1.4
Okla. 4/	83,133	8,018,582	96.45	(6/)	-.1	-.8	+1.5
Oreg.	10,573	741,959	70.17	-.2	-2.7	-11.0	-6.7
Pa.	46,739	3,481,358	74.49	+.5	-16.6	-1.7	+1.6
P. R.	31,187	280,546	9.00	-.6	-4.4	-6.5	-9.4
R. I. 4/	5,989	570,206	95.21	-.1	+.6	-.9	+11.0
S. C.	25,810	1,338,247	51.85	(6/)	-2.7	-3.9	-5.0
S. Dak.	7,177	608,227	84.75	-.1	+.2	-4.8	-1.9
Tenn.	45,058	2,404,496	53.36	-.2	-.5	-4.4	+.7
Tex.	230,179	16,118,173	70.02	+.1	(3/)	+.8	+.4
Utah	4,883	319,796	65.49	-.2	-5.0	-7.6	-15.5
Vt. 4/	5,469	461,838	84.45	+.4	-.3	+.2	-1.5
V. I.	447	18,014	40.30	+.2	+.4	-6.5	+1.8
Va.	13,368	851,334	63.68	-.3	+.5	-1.5	+2.3
Wash.	32,912	2,724,378	82.78	-.2	+2.6	-5.5	+5.9
W. Va.	14,299	710,537	49.69	-.5	-.1	-6.3	-.8
Wis.	28,912	3,065,825	106.04	-.1	-.1	-4.4	-7.7
Wyo.	2,476	210,495	85.01	-.7	+.2	-4.8	-.1

1/ All data subject to revision. 2/ Includes 3,827 recipients aged 60-64 in Colorado and payments of $334,979 to these recipients. Such payments were made without Federal participation. 3/ Increase of less than 0.05 percent. 4/ Represents aid to the aged under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged. 5/ In addition, supplemental payments of $21,266 from general assistance funds were made to 23 recipients. 6/ Decrease of less than 0.05 percent. 7/ Data for June; later data not available.

Table 4. Medical assistance for the aged: Recipients and payments for recipients, by State, November 1964 1/

State	Number of recipients 2/	Payments for recipients		Percentage change from October 1964	
		Total amount	Average	Number	Amount
Total	217,336	$39,963,969	$183.88	-1.6	-8.6
Ala.	225	71,573	318.10	-10.0	-4.2
Ark.	2,821	143,347	50.81	-2.0	-14.7
Calif.	28,600	8,534,936	298.42	+4.9	+6.0
Colo.	4,304	3/ 820,973	190.75	+4.1	+12.5
Conn.	6,219	1,177,297	189.31	-3.1	-12.0
D. C.	364	96,909	266.23	-56.9	-57.9
Fla. 4/	572	206,052	360.23	+9.6	+3.0
Guam 5/	23	1,108	(6/)	---	---
Hawaii 4/	545	142,488	261.45	+6.7	+3.5
Idaho	2,103	273,981	130.28	-2.3	-6.8
Ill. 4/	1,021	390,529	382.50	-13.1	-22.5
Iowa	7,062	539,644	76.42	+5.5	+5.7
Kans.	2,565	3/ 356,742	139.08	-3.0	-11.8
Ky. 4/	7,463	232,397	31.14	-3.8	+3.1
La.	451	78,830	174.79	+3.9	-9.2
Maine 4/	297	75,874	255.47	-36.1	-38.4
Md. 4/	10,844	404,530	37.30	+2.4	+9.1
Mass.	28,503	3/ 4,656,243	163.36	+5.0	+4.5
Mich.	5,221	1,871,862	358.53	-7.9	-6.8
Minn.	11,754	3/ 2,415,325	205.49	+5.5	+6.8
Nebr.	208	68,785	330.70	+31.6	+30.6
N. H.	1,696	79,955	47.14	-3.5	-12.3
N. J.	5,287	3/ 1,323,161	250.27	+.4	+3.7
N. Y.	33,143	3/ 9,511,267	286.98	-6.8	-17.5
N. C.	(7/)	(7/)	(7/)	(7/)	(7/)
N. Dak 4/	8/ 1,227	3/ 265,794	216.62	+.2	+1.6
Okla. 4/	899	132,382	147.25	-21.2	-30.1
Oreg.	3,911	580,750	148.49	+.7	+5.1
Pa.	9,295	2,218,354	238.66	-30.7	-46.7
P. R.	3,572	105,283	29.47	-14.2	-5.0
S. C.	958	133,580	139.44	-21.9	-35.4
S. Dak.	430	25,560	59.44	+13.5	+28.1
Tenn.	6,582	278,246	42.27	-8.6	-6.0
Utah	2,123	229,565	108.13	-3.3	-8.0
Vt. 4/	151	33,337	220.77	+38.5	+6.8
V. I.	35	612	(6/)	(6/)	(6/)
Va.	1,942	174,799	90.01	+2.9	-3.7
Wash.	9,709	1,415,224	145.76	-.1	+3.7
W. Va.	12,165	351,024	28.86	+27.2	+60.0
Wis.	3,030	527,175	173.99	+12.9	-15.7
Wyo.	16	18,476	(6/)	(6/)	(6/)

1/ All data subject to revision. 2/ Persons for whom vendor payments were made during the report month. 3/ Includes money payments not subject to Federal participation as follows: $60 in Colorado, $10,877 in Kansas, $99,208 in Massachusetts, $35,110 in Minnesota, $8,155 in New Jersey, $51,871 in New York, and $2,680 in North Dakota. 4/ Represents medical assistance for the aged under program for aid to the aged, blind, or disabled and medical assistance for the aged. 5/ Data for June; later data not available. 6/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients. 7/ Program in operation but no payments made in November 1964. 8/ Includes an unknown number of cases receiving only money payments.

Table 5. Aid to the blind: Recipients and payments to recipients, by State, November 1964 1/

[Includes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	October 1964 in--		November 1963 in--	
				Number	Amount	Number	Amount
Total 2/	96,416	$8,194,036	$84.99	-0.2	-0.5	-1.5	+2.5
Ala.	1,813	122,923	67.80	+.4	+.3	+5.7	+43.8
Alaska 3/	108	8,649	80.08	-.9	-.2	+2.9	+7.1
Ariz.	821	58,945	71.80	-.8	-1.5	-1.9	-2.8
Ark.	1,947	137,144	70.44	-.2	-1.6	-1.8	+5.4
Calif. 2/	12,479	1,640,037	131.42	+.3	-1.4	+3.3	+6.6
Colo.	251	20,066	79.94	-2.3	+.8	-1.2	-5.0
Conn.	311	33,579	107.97	-2.8	-19.1	+.3	-5.0
Del.	292	24,716	84.64	-2.3	-4.7	+.7	+15.1
D. C.	199	14,686	73.80	-1.0	-1.4	+5.3	+7.3
Fla. 3/	2,579	175,088	67.89	-.7	-.4	+.7	+1.8
Ga.	3,200	190,928	59.67	0	-1.1	+2.1	+5.6
Guam 4/	6	132	(5/)	---	---	---	---
Hawaii 3/	74	9,102	123.00	(5/)	(5/)	(5/)	(5/)
Idaho	134	9,777	72.96	-.7	-.6	+8.1	+11.8
Ill. 3/	2,480	233,044	93.97	-.4	-.9	-9.3	-1.2
Ind.	1,775	160,623	90.49	+.1	+2.5	-2.4	+3.4
Iowa	1,170	118,405	101.20	-.8	+.7	-5.7	-5.2
Kans.	513	49,951	97.37	-.8	-1.2	-3.6	+5.3
Ky. 3/	2,453	170,836	69.64	+.1	-.5	+1.9	+2.9
La.	2,790	225,969	80.99	-.5	-.7	-.7	-.8
Maine 3/	321	26,963	84.00	-1.5	-1.3	-17.5	-16.8
Md. 3/	383	31,086	81.16	-.5	-.8	-5.0	-.4
Mass.	2,293	314,673	137.23	+.8	+1.6	+.5	+5.3
Mich.	1,673	151,308	90.44	+.6	+1.4	-1.3	+10.3
Minn.	1,055	124,467	117.98	-.5	+6.5	+1.0	+11.1
Miss.	2,715	121,144	44.62	-.9	-.6	-11.0	-7.7
Mo. 2/	4,474	335,550	75.00	-.6	-.6	-3.4	-3.4
Mont.	246	21,070	85.65	-.4	+2.5	-7.2	+1.3
Nebr.	634	68,756	108.45	-.2	-.6	-4.7	+3.2
Nev.	162	18,969	117.09	+1.9	+3.3	+1.9	-1.3
N. H.	273	28,976	106.14	+.7	-.7	+1.5	+3.1
N. J.	944	83,113	88.04	+.1	+2.5	-.7	+5.6
N. Mex. 3/	343	32,778	95.56	-.9	-.4	+.3	+2.5
N. Y.	3,125	359,555	115.06	-.3	-2.2	-1.7	+7.3
N. C.	5,008	343,011	68.49	-.1	+1.2	-2.0	+4.4
N. Dak. 3/	78	6,112	78.36	(5/)	(5/)	(5/)	(5/)
Ohio	3,298	273,770	83.01	-1.4	-.9	-3.5	-5.6
Okla. 3/	1,646	202,162	122.82	-.6	-.9	-3.3	-.5
Oreg.	433	40,004	92.39	+2.4	+5.0	+11.6	+23.5
Pa. 2/	17,774	1,332,940	74.99	-.2	-1.2	-1.2	(6/)
P. R.	1,408	11,819	8.39	-.7	-.3	-10.0	-9.5
R. I. 3/	102	9,658	94.69	-1.0	+3.8	(5/)	(5/)
S. C.	1,828	112,700	61.65	+.4	-.5	+7.0	+8.1
S. Dak.	120	8,703	72.53	+.8	+3.9	-12.4	-3.9
Tenn.	2,141	111,274	51.97	-.3	-.2	-8.0	-6.7
Tex.	4,765	331,202	69.51	+.2	+.4	-2.9	-2.4
Utah	172	11,746	68.29	0	-1.5	-1.7	-10.0
Vt. 3/	118	8,374	70.97	+.9	-.9	+7.3	+6.1
V. I.	15	595	(5/)	(5/)	(5/)	(5/)	(5/)
Va.	1,142	80,227	70.25	+.4	-.7	-.7	+5.8
Wash.	664	61,303	92.32	-.9	+4.4	-.9	+7.3
W. Va.	805	38,421	47.73	+.1	+.7	-6.5	-6.9
Wis.	804	81,820	101.77	+.6	+.1	-3.5	-7.7
Wyo.	59	5,187	87.92	(5/)	(5/)	(5/)	(5/)

1/ All data subject to revision. 2/ Data include recipients of payments made without Federal participation and payments to these recipients as follows: California, $22,052 to 136 recipients; Missouri, $52,731 to 686 recipients; and Pennsylvania, $945,307 to 12,870 recipients. 3/ Represents aid to the blind under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 4/ Data for June; later data not available. 5/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients. 6/ Decrease of less than 0.05 percent.

Table 6. Aid to the permanently and totally disabled: Recipients and payments to recipients, by State, November 1964 1/

[Includes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	October 1964 in--		November 1963 in--	
				Number	Amount	Number	Amount
Total.....	521,789	$41,291,845	$79.14	+0.5	(2/)	+9.3	+14.9
Ala.....	14,842	683,308	46.04	(2/)	0.4	+6.3	+6.4
Alaska 3/.....	192	32,039	166.87	+1.6	+21.7	(4/)	(4/)
Ariz.....	3,274	220,499	67.35	+2.3	+2.3	+36.1	+35.2
Ark.....	9,419	564,006	59.88	+.6	-.2	+4.1	+11.0
Calif.....	54,378	6,136,690	112.85	+2.2	-.1	+37.6	+44.4
Colo.....	10,144	479,374	47.26	+.5	+21.8	+71.2	+10.0
Conn.....	7,648	570,470	74.59	+1.2	-9.5	+9.6	+25.4
Del.....	433	32,892	75.96	+.7	+2.8	+3.6	+9.4
Dist. of Col.....	3,102	231,392	74.59	-2.6	-8.2	+4.4	-.6
Fla. 3/.....	17,021	1,237,901	72.73	+.8	+2.2	+11.4	+17.4
Ga.....	26,807	1,598,687	59.64	+.5	+1.0	+4.8	+7.2
Guam 5/.....	54	1,348	24.96	---	---	---	---
Hawaii 3/.....	993	113,081	113.88	-4.1	-12.7	-6.2	-7.7
Idaho.....	2,951	167,460	56.75	+.5	+.5	+15.5	+19.3
Ill. 3/.....	28,542	2,760,435	96.71	+.3	+.5	+2.2	+5.5
Ind.....	1,334	141,884	106.36	+2.8	-2.6	+93.3	+81.8
Iowa.....	1,223	100,470	82.15	+1.2	+.5	+19.0	+18.1
Kans.....	4,844	522,433	107.85	+.9	-3.7	+10.0	+10.5
Ky. 3/.....	10,368	750,539	72.39	+.8	+1.5	+10.7	+10.0
La.....	19,308	1,127,059	58.37	+.2	+.2	+4.4	+6.4
Maine 3/.....	2,261	199,150	88.08	+.6	+.9	-5.0	-4.0
Md. 3/.....	7,634	601,441	78.78	+.3	+.5	+10.0	+12.5
Mass.....	12,420	1,752,136	141.07	+.7	+.3	+12.7	+14.7
Mich.....	9,175	979,088	106.71	+3.9	+2.9	+29.8	+42.1
Minn.....	3,661	223,500	61.05	+1.0	+.9	+13.3	+13.5
Miss.....	18,335	795,241	43.37	+.6	+.5	+11.9	+10.9
Mo.....	14,927	1,061,087	71.09	+.2	+.7	+2.3	+6.7
Mont.....	1,325	103,862	78.39	+1.4	+1.9	+5.1	+8.3
Nebr.....	2,569	244,262	95.08	+1.0	+1.5	+10.7	+24.6
N. H.....	598	68,003	113.72	+1.4	+.5	+7.9	+10.5
N. J.....	8,635	850,566	98.50	+.4	+1.2	+6.4	+11.2
N. Mex. 3/.....	3,824	349,285	91.34	+.4	+.4	+13.1	+14.2
N. Y.....	34,712	4,553,389	131.18	-.8	-1.0	+1.1	+9.3
N. C.....	22,002	1,523,166	69.23	-.2	-2.8	+4.3	+8.1
N. Dak. 3/.....	1,562	180,547	115.59	+.3	-.8	+18.6	+22.0
Ohio.....	19,095	1,436,589	75.23	-1.0	-3.1	+4.5	+1.4
Okla. 3/.....	13,756	1,542,404	112.13	+1.2	+1.5	+12.6	+16.4
Oreg.....	8,040	546,642	67.99	+2.2	+3.1	+6.9	+12.2
Pa.....	20,246	1,514,088	74.78	+.7	-2.1	+4.4	+21.1
P. R.....	20,877	179,529	8.60	-.7	-1.4	-3.3	-3.1
R. I. 3/.....	2,797	264,260	94.48	+1.2	+1.8	+4.0	+8.0
S. C.....	8,866	473,755	53.44	+.5	-3.9	+5.8	+3.8
S. Dak.....	1,107	77,234	69.77	+.2	+1.0	-.5	+1.9
Tenn.....	12,956	662,576	51.14	+.6	+.8	+4.8	+7.1
Tex.....	9,701	554,688	57.18	+.6	+.6	+9.8	+9.2
Utah.....	4,913	326,709	66.50	-.2	-4.9	+5.6	-3.1
Vt. 3/.....	1,169	99,307	84.95	+2.0	+5.2	+18.8	+33.9
V. I.....	83	3,265	39.34	(4/)	(4/)	(4/)	(4/)
Va.....	6,886	467,682	67.92	+.6	+2.2	+5.0	+6.7
Wash.....	18,134	1,137,321	62.72	-.4	+3.7	-1.6	+17.3
W. Va.....	5,933	300,561	50.66	-.3	-.2	-7.8	-5.2
Wis.....	6,084	692,720	113.86	+.8	+.6	+8.8	+6.7
Wyo.....	629	55,825	88.75	-.5	+5.9	+2.9	+13.5

1/ All data subject to revision. 2/ Increase of less than 0.05 percent. 3/ Represents aid to the permanently and totally disabled under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 4/ Percentage change not computed on fewer than 100 recipients. 5/ Data for June; later data not available.

Table 7. Aid to families with dependent children: Recipients and payments to recipients, by State, November 1964 1/

[Includes vendor payments for medical care and cases receiving only such payments]

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
					Average per--		Oct 1964 in--		November 1963 in--	
		Total 2/	Children	Total amount	Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total 3/ 4/...	1,010,016	4,195,113	3,152,468	$139,295,652	$137.91	$33.20	+0.5	-0.1	+7.0	+13.4
Ala. 3/.....	18,942	77,572	61,287	902,537	47.65	11.63	-1.6	-1.4	-14.4	-14.2
Alaska 3/.....	1,227	4,487	3,437	155,965	127.11	34.76	+1.9	+.5	+1.9	+2.9
Ariz. 3/.....	9,319	39,861	30,138	1,136,048	121.91	28.50	+1.2	+.7	-5.6	-5.7
Ark.....	7,035	29,023	21,799	489,398	69.57	16.86	+.7	+1.2	+9.9	+9.8
Calif. 3/ 4/..	120,919	490,844	365,288	21,387,812	176.88	43.57	+2.0	+1.5	+34.2	+33.6
Colo.....	10,467	40,973	31,840	1,477,367	141.15	36.06	-.2	+2.6	+5.5	+10.0
Conn. 4/.....	14,367	57,132	41,607	2,645,621	184.15	46.31	-.7	-2.3	+15.5	+13.4
Del. 4/.....	2,583	11,668	8,823	326,970	126.59	28.02	+1.2	+3.3	+16.7	+50.1
D. C.....	4,106	19,606	15,786	643,639	156.76	32.83	-.2	(5/)	+8.4	+9.5
Fla.....	27,899	105,941	85,315	1,706,337	61.16	16.11	+.4	+.9	+1.8	+.9
Ga.....	17,058	69,199	53,016	1,526,679	89.50	22.06	+2.4	+2.2	+16.5	+10.8
Guam 6/.....	123	629	524	7,767	63.15	12.35	---	---	---	---
Hawaii 4/.....	3,152	13,487	10,002	485,728	154.10	36.01	-.7	+3.5	-2.2	+6.9
Idaho.....	2,481	9,548	6,960	369,112	148.78	38.66	+1.1	+1.9	-1.5	-4.2
Ill. 3/ 4/....	54,669	257,018	198,329	11,558,865	211.43	44.97	-.2	+.3	-.1	+8.0
Ind. 4/.....	11,726	47,729	35,710	1,386,897	118.28	29.06	-.7	(7/)	+2.0	+5.9
Iowa.....	10,678	42,782	31,142	1,650,511	154.57	38.58	-.3	+.1	+3.0	+30.1
Kans. 3/ 4/...	8,275	34,861	26,753	1,324,223	160.03	37.99	-.1	-4.4	+13.0	+14.5
Ky. 3/.....	20,363	79,293	57,013	1,916,235	94.10	24.17	+.5	-1.7	+6.5	+2.5
La. 3/.....	23,616	103,084	78,129	2,380,433	100.80	23.09	+.3	+.7	+4.1	+4.8
Maine.....	5,233	19,059	14,051	549,208	104.95	28.82	+1.3	+.7	-8.0	-9.4
Md. 3/ 4/.....	17,738	75,969	58,628	2,500,527	140.97	32.92	+1.3	+1.0	+21.6	+24.0
Mass. 4/.....	24,692	92,443	69,260	4,323,412	175.09	46.77	+.8	-1.7	+14.7	+11.6
Mich. 3/ 4/...	38,645	157,011	115,636	5,735,075	148.40	36.53	-.3	+.2	+25.6	+26.2
Minn. 3/.....	13,448	49,511	38,673	2,528,411	188.01	51.07	+.1	+3.2	+13.0	+16.4
Miss.....	20,714	82,500	65,937	816,923	39.44	9.90	-.6	-.4	+2.0	+5.1
Mo. 3/.....	25,925	106,011	80,959	2,561,583	98.81	24.16	+.1	-.2	+1.2	+3.4
Mont.....	1,768	7,006	5,399	249,585	141.17	35.62	+1.6	+2.1	+1.3	+6.8
Nebr.....	3,798	15,601	12,018	470,940	124.00	30.19	+.3	-.3	+11.6	+13.7
Nev.....	1,198	4,888	3,866	153,748	128.34	31.45	+2.4	+3.1	-.2	-.8
N. H.....	1,062	4,393	3,284	195,252	183.85	44.45	+.6	+2.1	+4.7	+13.9
N. J.....	25,954	102,218	77,425	5,058,651	194.91	49.49	+.5	+1.3	+10.4	+15.0
N. Mex. 3/....	7,481	30,654	23,263	1,054,720	140.99	34.41	-1.3	-1.2	-.3	+1.1
N. Y. 4/.....	115,736	497,579	366,116	23,414,456	202.31	47.06	+.3	-2.0	+11.6	+21.8
N. C... 3/....	26,442	109,592	81,823	2,644,451	100.01	24.13	+.6	-.8	-2.0	+.4
N. Dak.....	1,892	7,480	5,713	324,682	171.61	43.41	+.1	+1.4	+11.0	+11.7
Ohio 4/.....	41,036	169,788	127,071	5,319,913	129.64	31.33	-.1	-1.9	+12.0	+14.8
Okla. 3/ 4/...	18,425	72,553	53,891	2,386,243	129.51	32.89	-.4	-.2	+1.0	-4.5
Oreg. 3/ 4/...	7,184	28,517	21,084	1,107,434	154.15	38.83	+3.1	+4.2	+4.7	+7.5
Pa. 4/.....	67,472	297,024	213,119	9,077,440	134.54	30.56	-.3	-3.1	-6.7	+.5
P. R.....	50,164	203,113	162,397	833,582	16.62	4.10	+.2	-.2	-4.9	+7.1
R. I. 4/.....	5,821	23,390	17,197	997,268	171.32	42.64	+.7	+1.1	+6.5	+13.3
S. C.....	7,348	29,531	23,743	467,029	63.56	15.81	+.1	-2.5	-8.0	-9.8
S. Dak.....	2,884	10,707	8,079	335,075	116.18	31.29	+2.0	+1.8	+6.0	+9.9
Tenn. 3/.....	18,863	75,192	56,992	1,514,846	80.31	20.15	-.4	-.7	-2.7	+5.3
Tex.....	19,604	89,661	67,593	1,657,718	84.56	18.49	+2.0	+2.4	+3.2	+6.4
Utah 3/ 4/....	4,850	20,011	14,523	675,040	139.18	33.73	-.5	+1.2	+10.9	+4.3
Vt.....	1,399	5,409	3,975	159,273	113.85	29.45	-.4	-.5	+11.5	+8.9
V. I.....	316	1,160	980	21,633	68.46	18.65	-.1	+2.4	+1.7	+13.2
Va. 3/.....	10,658	45,550	35,104	1,116,979	104.80	24.52	+1.2	+1.8	+4.2	+7.7
Wash. 3/ 4/...	16,237	64,537	46,388	2,290,529	141.07	35.49	+5.1	+5.9	+16.6	+16.7
W. Va. 3/ 4/..	24,944	114,643	79,263	3,040,147	121.88	26.52	+.6	+.5	-6.4	-6.6
Wis. 3/.....	11,202	44,281	33,440	2,104,656	187.88	47.53	+.7	+.4	+3.7	+1.9
Wyo.....	878	3,394	2,630	131,079	149.29	38.62	+1.4	+4.6	+5.1	+8.5

1/ All data subject to revision. 2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 3/ Includes data on foster-family care; see table 10. 4/ Includes data on unemployed-parent segment; see table 8. 5/ Increase of less than 0.05 percent. 6/ Data for June; later data not available. 7/ Decrease of less than 0.05 percent.

Table 8. Aid to families with dependent children, unemployed-parent segment: Recipients and payments to recipients, November 1964 1/

/Includes vendor payments for medical care and cases receiving only such payments/

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
		Total 2/	Children	Total	Average per--		October 1964 in--		November 1963 in--	
					Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total...	58,341	337,353	226,318	$10,882,045	$186.52	$32.26	+1.6	+2.0	+22.6	+31.7
Calif.....	9,630	55,845	37,757	1,971,871	204.76	35.31	+13.5	+12.9	(3/)	(3/)
Conn.....	1,713	9,575	6,319	322,843	188.47	33.72	-4.2	-2.4	-3.6	-5.7
Del.....	303	1,796	1,230	47,357	156.29	26.37	+4.0	+9.5	-4.3	+19.6
Hawaii....	268	1,685	1,158	47,336	176.63	28.09	-4.2	-.7	-25.3	-22.0
Ill.....	5,851	38,262	26,785	1,590,497	271.83	41.57	-3.4	-3.0	-19.4	-14.0
Kans.....	349	2,128	1,440	71,847	205.87	33.76	-2.9	+1.5	+83.8	+94.4
Md.....	384	2,351	1,593	68,311	177.89	29.06	+.5	+3.5	+5.3	+10.3
Mass.....	636	3,515	2,373	124,233	195.33	35.34	+1.7	+2.5	+10.4	+11.8
Mich.....	3,241	20,240	13,874	650,681	200.77	32.15	-4.5	-5.1	(3/)	(3/)
N. Y.....	13,323	76,604	51,949	2,688,005	201.76	35.09	-1.1	+.7	+5.4	+15.4
Ohio.....	1,929	11,142	7,517	315,482	163.55	28.31	+.2	-5.2	(3/)	(3/)
Okla.....	10	51	35	1,515	(4/)	(4/)	(4/)	(4/)	(4/)	(4/)
Oreg.....	579	3,452	2,361	122,956	212.36	35.62	+21.8	+20.4	+28.1	+27.5
Pa.....	6,881	37,888	24,643	918,368	133.46	24.24	-2.6	-4.5	-33.8	-32.7
R. I.....	477	2,725	1,794	99,150	207.86	36.39	-.4	-1.0	-12.2	-4.1
Utah.....	760	4,252	2,941	88,422	116.34	20.80	-3.8	+27.1	+7.0	+1.8
Wash.....	1,829	10,201	6,599	260,152	142.24	25.50	+27.6	+29.1	+29.7	+42.9
W. Va.....	10,178	55,641	35,950	1,493,019	146.69	26.83	+1.2	+1.1	-6.3	-6.5

1/ Data for this segment of the program, shown separately here, are included in data for the total program. All data subject to revision. 2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 3/ No program in operation in November 1963. 4/ Average payment not computed on base of fewer than 50 families; percentage change on fewer than 100 recipients.

Table 9. Aid to families with dependent children: Recipients and money payments to recipients under community work and training programs, by State, November 1964 1/

State	Number of families with an adult on work and training programs	Number of recipients				Money payments to recipients			
		Total 2/	Adults		Children	Total	For work performed on work and training programs	Average per family	
			On work and training programs	Other				Total	For work performed on work and training programs
Total.....	19,636	111,868	19,638	17,961	74,269	$3,312,695	$2,341,127	$168.71	$119.23
Calif.....	4,555	26,395	4,555	4,001	17,839	1,032,052	310,062	226.58	68.07
Ill.....	2,480	15,701	2,482	2,187	11,032	565,777	426,630	228.14	172.03
Kans.....	86	520	86	83	351	22,822	9,838	265.37	114.40
Mich.....	(3/)	(3/)	(3/)	(3/)	(3/)	(3/)	(3/)	(3/)	(3/)
Md.....	122	749	122	120	507	22,551	12,221	184.84	100.17
Ohio.....	1,111	6,540	1,111	979	4,450	183,560	164,368	165.22	147.95
Oreg.....	147	803	147	121	535	31,463	9,760	214.03	66.39
Pa. 4/.....	576	3,317	576	576	2,165	103,192	69,586	179.15	120.81
Wash.....	381	2,202	381	381	1,440	53,800	41,184	141.21	108.09
W. Va.....	10,178	55,641	10,178	9,513	35,950	1,297,478	1,297,478	127.48	127.48

1/ Represents data for community work and training programs under plans for such programs submitted under Section 409 of Social Security Act. 2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 3/ Data not reported. 4/ Plan material submitted but not yet approved.

Table 10. Aid to families with dependent children receiving foster care: Recipients and payments for foster care, by State, November 1964 1/

State	Number of--				Payments for foster care			
	Children receiving foster care			Families from which children were removed	Total amount	Average per child	In foster homes	In institutions
	Total	In foster homes	In institutions					
Total.....	5,318	2/ 4,129	2/ 250	2,263	$409,510	$77.00	2/ $274,611	2/ $33,562
Ala.....	11	11	0	5	431	(3/)	431	0
Alaska.....	61	61	0	21	5,967	97.82	5,967	0
Ariz.....	175	175	0	66	8,399	47.99	8,399	0
Calif.....	1,103	985	118	562	104,151	94.43	81,236	22,915
Ill.....	939	(2/)	(2/)	370	101,337	107.92	(2/)	(2/)
Ind.....	117	117	0	39	4,766	40.74	4,766	0
Kans.....	71	64	7	30	6,033	84.97	5,822	211
Ky.....	15	15	0	6	1,050	(3/)	1,050	0
La.....	495	466	29	204	33,768	68.22	31,033	2,735
Md.....	449	420	29	160	32,907	73.29	30,499	2,408
Mich.....	47	45	2	17	3,208	(3/)	2,968	240
Minn.....	155	111	44	78	13,098	84.50	9,335	3,763
Mo.....	58	58	0	25	1,838	31.69	1,838	0
N. Mex.....	55	55	0	16	3,511	63.84	3,511	0
N. C.....	20	20	0	5	906	(3/)	906	0
Okla.....	281	281	0	119	12,950	46.09	12,950	0
Oreg.....	95	95	0	41	6,024	63.41	6,024	0
Tenn.....	256	240	16	84	16,665	65.10	15,682	983
Utah.....	193	193	0	85	10,570	54.77	10,570	0
Va.....	48	48	0	18	2,082	(3/)	2,082	0
Wash.....	521	521	0	238	29,786	57.17	29,786	0
W. Va.....	27	22	5	16	1,533	(3/)	1,226	307
Wis.....	126	126	0	58	8,530	67.70	8,530	0

1/ Data for this segment of the program, shown separately here, are included in data for the total program. All data subject to revision. 2/ Excludes Illinois; breakdown not available. 3/ Average payment not computed on base of fewer than 50 children.

Table 11. General assistance: Recipients and payments to recipients, by State, November 1964 1/

/Excludes vendor payments for medical care and cases receiving only such payments/

State	Number of--		Payments to recipients			Percentage change from--			
				Average per--		October 1964 in--		November 1963 in--	
	Cases	Recipients	Total amount	Cases	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total 2/.....	322,000	703,000	$21,389,000	$66.34	$30.41	+1.9	-1.3	-7.9	+0.8
Ala.....	80	80	1,014	12.68	12.68	(3/)	(3/)	(3/)	(3/)
Alaska.....	254	600	10,491	41.30	17.48	+25.3	+11.4	-20.5	-33.3
Ariz.....	1,988	4,932	109,720	55.19	22.25	-4.5	+.2	+6.0	-7.2
Ark.....	308	1,079	4,689	15.22	4.35	-16.7	-16.3	-3.5	+6.9
Calif.....	24,914	42,159	1,505,464	60.43	35.71	+10.7	+4.1	-47.0	-23.4
Colo.....	1,502	5,290	73,687	49.06	13.93	+38.4	+39.4	+27.0	+33.8
Conn.....	4/ 3,969	4/ 9,548	4/ 264,494	66.64	27.70	-2.2	-1.6	-5.4	-3.0
Del.....	1,498	2,658	76,855	51.31	28.91	+3.7	+3.6	+4.0	+3.3
D. C.....	683	747	51,755	75.78	69.28	+.9	-.8	+36.3	+39.1
Fla. 5/.....	7,900	(6/)	244,000	---	---	---	---	---	---
Ga.....	2,294	5,539	70,092	30.55	12.65	-1.6	-3.6	+12.6	-.4
Guam 7/.....	14	29	524	(3/)	(3/)	---	---	---	---
Hawaii.....	1,071	1,339	74,980	70.01	56.00	-.9	-.2	+2.4	+10.0
Ill.....	26,347	55,001	2,053,552	77.94	37.34	-1.7	-8.8	(8/)	+.1
Iowa 5/.....	3,600	7,800	130,000	---	---	---	---	---	---
Kans.....	2,821	6,664	186,151	65.99	27.93	+4.0	+1.3	-8.4	+1.3
Ky.....	1,325	4,055	50,790	38.33	12.53	+6.0	+5.0	-14.9	-12.1
La.....	8,230	9,026	428,892	52.11	47.52	+.3	+.2	+2.7	+3.0
Maine.....	2,620	8,432	114,439	43.68	13.57	+21.4	+19.7	+4.7	+14.7
Md.....	6,742	7,682	496,458	73.64	64.63	+2.0	+1.7	+31.2	+32.6
Mass.....	7,479	15,245	522,095	69.81	34.25	+.3	-.7	-1.1	+2.0
Mich.....	21,485	66,005	1,668,190	77.64	25.27	-7.1	-13.7	-29.2	-33.9
Minn.....	9,865	26,670	767,392	77.79	28.77	+6.0	-1.7	+1.8	+4.8
Miss.....	1,307	1,720	19,724	15.09	11.47	+4.7	+2.6	+22.7	+26.0
Mo.....	9,779	12,698	648,975	66.36	51.11	+.8	+1.2	+5.3	+6.2
Mont.....	1,090	3,270	58,480	53.65	17.88	+15.3	+14.4	-20.6	+7.0
Nev.....	377	758	21,283	56.45	28.08	+26.1	+6.5	+14.2	+19.0
N. H.....	924	3,041	54,036	58.48	17.77	-1.1	+2.8	+2.5	+5.2
N. J. 9/.....	9,425	30,475	1,117,249	118.54	36.66	+2.9	-2.0	+2.3	+4.1
N. Mex.....	548	760	20,629	37.64	27.14	-7.4	-6.8	-13.6	-12.4
N. Y. 10/.....	45,856	100,468	3,990,390	87.02	39.72	+1.1	+.5	+20.5	+31.9
N. C.....	1,706	4,713	44,481	26.07	9.44	-6.3	-9.4	-10.9	-4.2
N. Dak.....	349	1,460	20,380	58.40	13.96	+24.1	+18.7	+3.6	-1.3
Ohio.....	27,260	90,465	1,925,611	70.64	21.29	+2.9	-.2	-11.8	-8.1
Okla.....	8,274	(6/)	97,991	11.84	---	---	+5.7	---	+21.0
Oreg.....	4,207	(6/)	230,394	54.76	---	---	+34.1	---	+68.8
Pa.....	35,661	43,152	2,300,666	64.51	53.32	-1.4	-.8	-3.8	+3.9
P. R.....	1,113	1,113	8,990	8.08	8.08	-15.1	-10.4	-.5	+6.7
R. I.....	3,139	7,042	188,987	60.21	26.84	-3.9	-19.2	+23.1	+29.1
S. C.....	1,260	1,468	39,206	31.12	26.71	0	-1.6	-8.5	-10.9
S. Dak.....	384	1,303	12,405	32.30	9.52	+17.0	+19.6	+40.7	+27.1
Tenn.....	1,752	3,480	40,763	23.27	11.71	+2.6	+.7	-36.5	+17.8
Tex. 11/ 12/....	9,700	(6/)	344,000	---	---	---	---	---	---
Utah.....	1,482	4,141	111,590	75.30	26.95	+21.1	+20.7	+13.8	+27.0
Vt. 11/ 12/.....	900	(6/)	23,000	-----	-----	---	---	---	---
V. I.....	176	183	6,513	37.01	35.59	-.5	-.7	+17.3	+27.0
Va.....	2,367	5,532	114,660	48.44	20.73	-15.4	-10.6	+6.8	+8.7
Wash.....	8,493	15,314	586,259	69.03	38.28	+19.3	+13.3	-.8	+12.0
W. Va.....	1,551	2,512	56,421	36.38	22.46	-12.0	-3.8	+20.9	+21.7
Wis.....	7,020	21,154	640,092	91.18	30.26	-2.3	-5.4	-8.9	-7.4
Wyo.....	339	1,267	25,085	74.00	19.80	+46.6	+43.3	+4.4	+17.1

1/ All data subject to revision. 2/ Partly estimated; does not represent sum of State figures because totals exclude for New Jersey an estimated number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services; recipient count also includes an estimate for States not reporting such data. Excludes Idaho, Indiana, and Nebraska; data not available. 3/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients. 4/ About 16 percent of this total is estimated. 5/ Partly estimated. 6/ Data not available. 7/ Data for June; later data not available. 8/ Increase of less than 0.05 percent. 9/ Includes an unknown number of cases and persons receiving only medical care, hospitalization, and/or burial, and total payments for such services. 10/ Includes an unknown number of cases and persons receiving only medical care. 11/ Estimated on basis of reports from sample of local jurisdictions. 12/ Data for October; November data not available.

Table 12. Amount of vendor payments for medical care for recipients of public assistance, by program and State, November 1964 1/

State	Old-age assistance	Medical assistance for the aged	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children	General assistance 1/
Total.....	$34,640,011	$39,963,969	$958,166	$9,975,660	$11,211,852	$9,265,000
Ala.....	1,084,163	71,573	4,359	64,912	1,254	28
Alaska 2/.....	40,781	---	---	19,759	212	58,445
Ariz.....	61,647	---	---	---	---	---
Ark.....	685,994	143,347	18,708	195,265	46,176	32,394
Calif.....	3,534,818	8,534,936	180,769	1,064,649	1,161,654	105,639
Colo.....	577,487	3/ 820,973	3,264	81,001	102,639	74,791
Conn.....	107,804	1,177,297	12,742	249,167	335,276	(4/)
Del.....	23,155	---	1,655	---	---	---
Dist. of Col.....	46,385	96,909	---	3,631	1,471	731
Fla. 2/.....	1,291,977	206,052	20,799	278,639	65,802	---
Ga.....	835,971	---	12,087	143,874	---	---
Guam 5/.....	1,434	1,108	---	---	---	---
Hawaii 2/.....	18,156	142,488	3,936	57,191	67,183	24,193
Idaho.....	50,640	273,981	---	21,654	---	---
Ill. 2/.....	2,639,628	390,529	74,850	812,588	1,574,353	6/ 850,450
Ind.....	832,086	---	50,706	77,063	224,663	---
Iowa.....	1,025,715	539,644	11,785	---	176,798	6/ 7/ 242,000
Kans.....	404,962	3/ 356,742	10,582	88,593	170,947	95,671
Ky. 2/.....	510,419	232,397	15,113	98,494	162,509	---
La.....	2,272,989	78,830	6,779	106,652	22,037	3,664
Maine 2/.....	327,214	75,874	3,692	41,828	26,165	83,313
Md. 2/.....	105,757	404,530	3,761	82,832	---	1,875
Mass.....	1,015,221	3/ 4,656,243	32,322	922,356	433,450	202,548
Mich.....	696,349	1,871,862	19,570	189,254	248,850	337,911
Minn.....	1,125,383	3/ 2,415,325	52,977	46,000	457,354	533,165
Miss.....	135,278	---	2,763	---	---	---
Mo.....	984,232	---	---	52,848	38,692	20,878
Mont.....	305	---	362	---	---	6/ 384,434
Nebr.....	622,729	68,785	33,783	123,464	40,488	---
Nev.....	59,245	---	3,464	(8/)	10,042	6/ 240,618
N. H.....	100,433	79,955	5,651	21,077	31,739	(4/)
N. J.....	261,769	3/ 1,323,161	11,325	253,159	267,021	264,586
N. Mex. 2/.....	227,020	---	7,460	83,980	137,984	19,388
N. Y.....	1,160,553	3/ 9,511,267	84,599	1,975,552	2,583,964	240,591
N. C.....	322,155	(9/)	26,713	219,298	182,607	6/ 105,998
N. Dak. 2/.....	131,646	3/ 265,794	836	82,661	57,064	6/ 15,995
Ohio.....	1,677,024	---	44,124	226,320	424,883	6/ 1,232,739
Okla. 2/.....	1,608,080	132,382	32,201	264,267	36,599	(4/)
Oreg.....	126,320	580,750	6,589	177,609	90,736	67,476
Pa.....	517,835	2,218,354	59,089	350,954	713,895	951,975
P. R.....	16,049	105,283	---	---	---	---
R. I. 2/.....	102,532	---	1,785	53,786	149,462	6/ 76,724
S. C.....	299,540	133,580	12,694	71,326	19,984	12,893
S. Dak.....	107,655	25,560	---	---	---	6/ 107,685
Tenn.....	497,018	278,246	4,068	31,094	56,603	---
Tex.....	2,848,928	---	---	---	---	---
Utah.....	40,340	229,565	2,175	126,156	40,975	239
Vt. 2/.....	202,986	33,337	1,390	28,773	---	---
V. I.....	1,341	612	4	83	158	166
Va.....	244,284	174,799	13,475	85,454	50,841	6/ 21,331
Wash.....	677,728	1,415,224	16,202	563,790	289,013	125,887
W. Va.....	155,551	351,024	4,788	64,680	403,844	14,168
Wis.....	2,156,075	527,175	41,179	461,426	297,578	294,934
Wyo.....	39,225	18,476	991	12,501	8,887	43,347

1/ Data incomplete. Some States do not report these data and for some the data represent only partial reporting. The total includes an estimated amount for these States. 2/ Except for aid to families with dependent children and general assistance, data represent payments for recipients of the specified type of assistance under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 3/ Includes money payments not subject to Federal participation as follows: $60 in Colorado, $10,877 in Kansas, $99,208 in Massachusetts, $35,110 in Minnesota, $8,155 in New Jersey, $51,871 in New York, and $2,680 in North Dakota. 4/ Data not available. 5/ Data for June; later data not available. 6/ Includes payments made in behalf of recipients of the special types of public assistance. 7/ Partly estimated. 8/ No program for aid to the permanently and totally disabled. 9/ Program in operation but no payments made in November 1964.

Table 13. Average payment per recipient for all assistance, for money payments, and for vendor payments for medical care, by program and State, November 1964 1/

State	Old-age assistance			Medical assistance for the aged	Aid to the blind			Aid to the permanently and totally disabled			Aid to families with dependent children (per recipient)		
	All assistance	Money payments to recipients	Vendor payments for medical care		All assistance	Money payments to recipients	Vendor payments for medical care	All assistance	Money payments to recipients	Vendor payments for medical care	All assistance	Money payments to recipients	Vendor payments for medical care
Total.....	$78.17	$62.14	$16.03	$183.88	$84.99	$75.05	$9.94	$79.14	$60.02	$19.12	$33.20	$30.53	$2.67
Ala.....	67.54	57.79	9.75	318.10	67.80	65.40	2.40	46.04	41.67	4.37	11.63	11.62	.02
Alaska 2/.....	99.81	69.93	29.88	(3/)	80.08	80.08	---	166.87	63.96	102.91	34.76	34.71	.05
Ariz.....	63.03	58.39	4.64	(3/)	71.80	71.80	---	67.35	67.35	---	28.50	28.50	---
Ark.....	63.27	51.62	11.65	50.81	70.44	60.83	9.61	59.88	39.15	20.73	16.86	15.27	1.59
Calif.....	108.23	95.30	12.94	298.42	131.42	116.94	14.49	112.85	93.27	19.58	43.57	41.21	2.37
Colo.....	93.15	80.22	12.93	190.75	79.94	66.94	13.00	47.26	39.27	7.99	36.06	33.55	2.51
Conn.....	77.00	62.04	14.96	189.31	107.97	67.00	40.97	74.59	42.01	32.58	46.31	40.44	5.87
Del.....	69.81	52.93	16.88	(3/)	84.64	78.98	5.67	75.96	75.96	---	28.02	28.02	---
D. C.....	83.47	64.16	19.31	266.23	73.80	73.80	---	74.59	73.42	1.17	32.83	32.75	.08
Fla. 2/.....	67.39	49.74	17.65	360.23	67.89	59.83	8.06	72.73	56.36	16.37	16.11	15.49	.62
Ga.....	56.39	47.33	9.06	(3/)	59.67	55.89	3.78	59.64	54.27	5.37	22.06	22.06	---
Guam 4/.....	35.40	26.38	9.02	(5/)	(5/)	(5/)	---	24.96	24.96	---	12.35	12.35	---
Hawaii 2/.....	74.32	58.81	15.50	261.45	123.00	69.81	53.19	113.88	56.28	57.59	36.01	31.03	4.98
Idaho.....	72.85	61.53	11.32	130.28	72.96	72.96	---	56.75	49.41	7.34	38.66	38.66	---
Ill. 2/.....	93.70	47.28	46.42	382.50	93.97	63.79	30.18	96.71	68.24	28.47	44.97	38.85	6.13
Ind.....	81.61	45.20	36.40	(3/)	90.49	61.93	28.57	106.36	48.59	57.77	29.06	24.35	4.71
Iowa.....	93.17	56.27	36.90	76.42	101.20	91.13	10.07	82.15	82.15	---	38.58	34.45	4.13
Kans.....	88.99	70.37	18.62	139.08	97.37	76.74	20.63	107.85	89.56	18.29	37.99	33.08	4.90
Ky. 2/.....	59.51	50.64	8.87	31.14	69.64	63.48	6.16	72.39	62.89	9.50	24.17	22.12	2.05
La.....	84.96	67.60	17.36	174.79	80.99	78.56	2.43	58.37	52.85	5.52	23.09	22.88	.21
Maine 2/.....	82.78	53.28	29.50	255.47	84.00	72.50	11.50	88.08	69.58	18.50	28.82	27.44	1.37
Md. 2/.....	72.85	62.10	10.75	37.30	81.16	71.34	9.82	78.78	67.93	10.85	32.92	32.92	---
Mass.....	89.31	70.38	18.92	163.36	137.23	123.14	14.10	141.07	66.81	74.26	46.77	42.08	4.69
Mich.....	92.43	78.33	14.10	358.53	90.44	78.74	11.70	106.71	86.09	20.63	36.53	34.94	1.58
Minn.....	86.83	52.56	34.26	205.49	117.98	67.76	50.22	61.05	48.48	12.56	51.07	41.83	9.24
Miss.....	39.00	37.16	1.84	(3/)	44.62	43.60	1.02	43.37	43.37	---	9.90	9.90	---
Mo.....	68.14	58.56	9.57	(3/)	75.00	75.00	---	71.09	67.54	3.54	24.16	23.80	.36
Mont.....	71.76	71.70	.06	(3/)	85.65	84.18	1.47	78.39	78.39	---	35.62	35.62	---
Nebr.....	90.41	40.69	49.72	330.70	108.45	55.16	53.29	95.08	47.02	48.06	30.19	27.59	2.60
Nev.....	89.61	66.98	22.62	(3/)	117.09	95.71	21.38	(3/)	(3/)	(3/)	31.45	29.40	2.05
N. H.....	102.93	80.34	22.58	47.14	106.14	85.44	20.70	113.72	78.47	35.25	44.45	37.22	7.22
N. J.....	81.25	62.38	18.87	250.27	88.04	76.05	12.00	98.50	69.18	29.32	49.49	46.88	2.61
N. Mex. 2/.....	79.38	58.12	21.26	(3/)	95.56	73.81	21.75	91.34	69.38	21.96	34.41	29.91	4.50
N. Y.....	94.89	74.26	20.63	286.98	115.06	87.99	27.07	131.18	74.26	56.91	47.06	41.86	5.19
N. C.....	59.62	52.12	7.50	(6/)	68.49	63.16	5.33	69.23	59.26	9.97	24.13	22.46	1.67
N. Dak. 2/.....	88.57	63.53	25.04	216.62	78.36	67.64	10.72	115.59	62.67	52.92	43.41	35.78	7.63
Ohio.....	86.07	65.90	20.17	(3/)	83.01	69.63	13.38	75.23	63.38	11.85	31.33	28.83	2.50
Okla. 2/.....	96.45	77.11	19.34	147.25	122.82	103.26	19.56	112.13	92.91	19.21	32.89	32.39	.50
Oreg.....	70.17	58.23	11.95	148.49	92.39	77.17	15.22	67.99	45.90	22.09	38.83	35.65	3.18
Pa.....	74.49	63.41	11.08	238.66	74.99	71.67	3.32	74.78	57.45	17.33	30.56	28.16	2.40
P. R.....	9.00	8.48	.51	29.47	8.39	8.39	---	8.60	8.60	---	4.10	4.10	---
R. I. 2/.....	95.21	78.09	17.12	(3/)	94.69	77.19	17.50	94.48	75.25	19.23	42.64	36.25	6.39
S. C.....	51.85	40.24	11.61	139.44	61.65	54.71	6.94	53.44	45.39	8.04	15.81	15.14	.68
S. Dak.....	84.75	69.75	15.00	59.44	72.53	72.53	---	69.77	69.77	---	31.29	31.29	---
Tenn.....	53.36	42.33	11.03	42.27	51.97	50.07	1.90	51.14	48.74	2.40	20.15	19.39	.75
Tex.....	70.02	57.65	12.38	(3/)	69.51	69.51	---	57.18	57.18	---	18.49	18.49	---
Utah.....	65.49	57.23	8.26	108.13	68.29	55.65	12.65	66.50	40.82	25.68	33.73	31.69	2.05
Vt. 2/.....	84.45	47.33	37.12	220.77	70.97	59.19	11.78	84.95	60.34	24.61	29.45	29.45	---
V. I.....	40.30	37.30	3.00	(5/)	(5/)	(5/)	(5/)	39.34	38.34	1.00	18.65	18.51	.14
Va.....	63.68	45.41	18.27	90.01	70.25	58.45	11.80	67.92	55.51	12.41	24.52	23.41	1.12
Wash.....	82.78	62.19	20.59	145.76	92.32	67.92	24.40	62.72	31.63	31.09	35.49	31.01	4.48
W. Va.....	49.69	38.81	10.88	28.86	47.73	41.78	5.95	50.66	39.76	10.90	26.52	23.00	3.52
Wis.....	106.04	31.47	74.57	173.99	101.77	50.55	51.22	113.86	38.02	75.84	47.53	40.81	6.72
Wyo.....	85.01	69.17	15.84	(5/)	87.92	71.12	16.80	88.75	68.88	19.87	38.62	36.00	2.62

1/ Averages based on cases receiving money payments, vendor payments for medical care, or both. Money payments may also include small amounts for assistance in kind and vendor payments for other than medical care. Averages for general assistance not computed because of difference among States in policy or practice regarding use of general assistance funds to pay medical bills for recipients of the special types of public assistance. 2/ Except for aid to families with dependent children, data for each program represent average payments for recipients of the specified type of assistance under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 3/ No program in operation. 4/ Data for June; later data not available. 5/ Average payment not computed on base of fewer than 50 recipients. 6/ Program in operation but no payments made in November 1964.

Old-age, survivors and disability insurance benefits, summary data, November 1964

CURRENT MONTH DATA

Type of benefit	Benefits awarded in November 1964		Benefits in current-payment status, end of November 1964			Amount of benefits paid 1/ in November 1964 (in thousands)
	Number	Average amount	Number	Monthly rate (in thousands)	Average amount	
Total, OASI and DI	253,116	---	---	---	---	$1,360,396
Total, OASI	218,099	---	---	---	---	1,248,401
Monthly benefits, OASI and DI	178,953	---	19,790,754	$1,323,412	---	1,345,309
Monthly benefits, OASI	143,936	---	18,221,356	1,222,064	---	1,233,314
Monthly benefits, DI	35,017	---	1,569,398	101,349	---	111,994
Old-age (retired-worker)	67,690	$81.26	10,659,131	826,350	$77.53	827,524
Disability (disabled-worker)	17,582	94.96	893,458	81,436	91.15	89,514
Wife's or husband's (OASI and DI)	25,436	39.08	2,789,545	110,723	39.69	112,630
Wife's or husband's (OASI)	20,220	40.15	2,608,319	104,884	40.21	105,959
Wife's or husband's (DI)	5,216	34.92	181,226	5,839	32.22	6,671
Widow's or widower's	20,924	73.77	2,147,005	145,492	67.77	150,005
Parent's	254	78.97	36,444	2,551	69.99	2,737
Child's (OASI and DI)	39,464	---	2,795,472	128,999	---	134,243
Child's (OASI--total)	27,245	---	2,300,758	114,926	---	118,434
Child's (OASI--life) 2/	6,364	28.92	426,372	11,998	28.14	12,353
Child's (OASI--survivor) 2/	20,881	53.65	1,874,386	102,928	54.91	106,081
Child's (DI)	12,219	28.55	494,714	14,073	28.45	15,809
Mother's	7,603	61.45	469,699	27,861	59.32	28,655
Lump-sum death payments	74,163	3/215.57	---	---	---	15,087

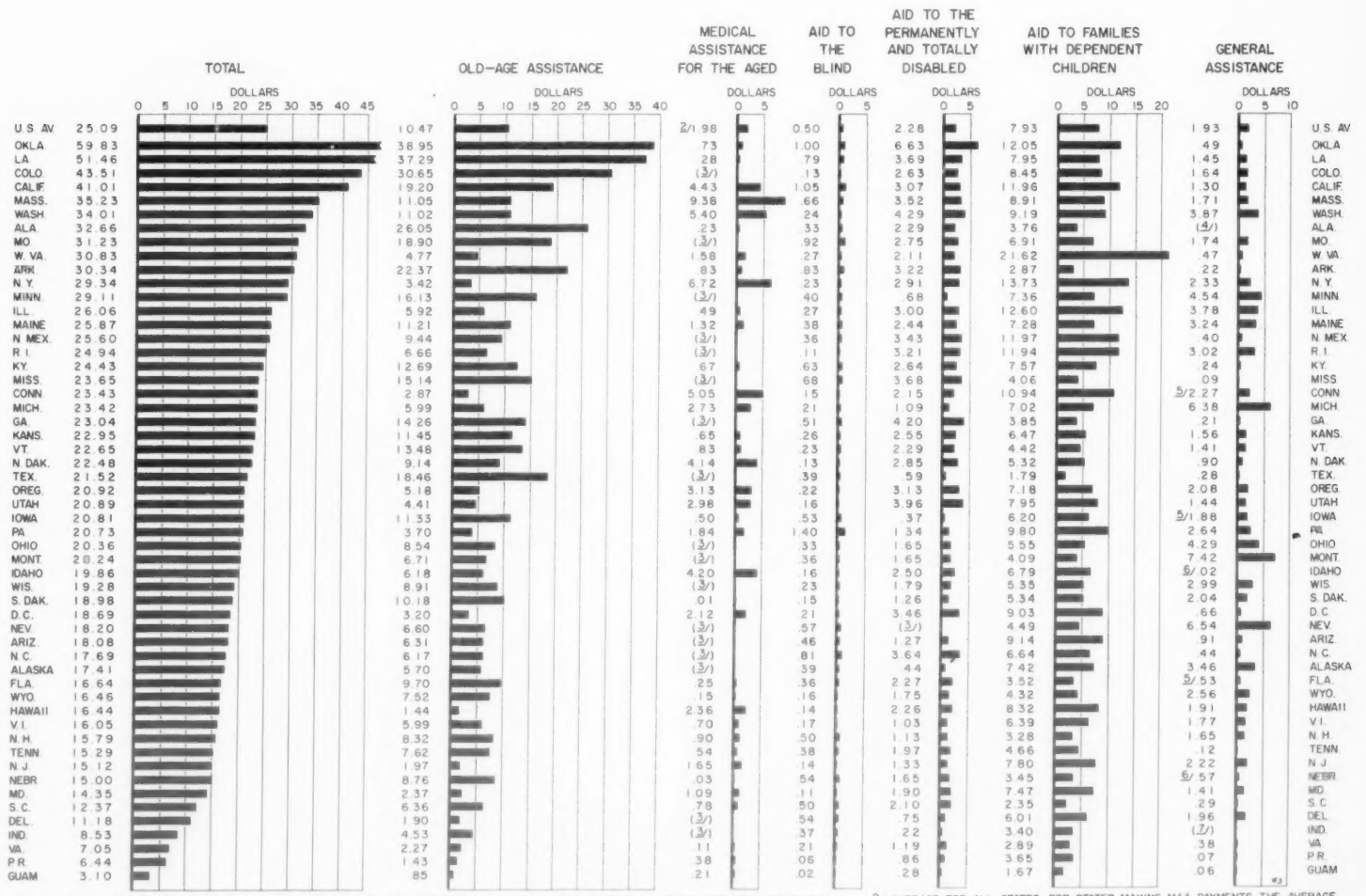
COMPARATIVE DATA

Item	November 1964	October 1964	November 1963
Number of benefits in current-payment status, end of month:	19,790,754	19,738,834	18,997,967
Total, OASI and DI	18,221,356	18,181,194	17,559,975
Total, OASI	1,569,398	1,557,640	1,437,992
Total, DI			
Amounts of benefits paid (in thousands):			
Total, OASI and DI	$1,360,396	$1,359,754	$1,292,288
Total, OASI	1,248,401	1,249,142	1,190,583
Total, DI	111,994	110,612	101,705
Number of old-age (retired-worker) benefits:			
Awarded	67,690	75,722	73,012
In current-payment status, end of month	10,659,131	10,627,643	10,248,092
Average old-age (retired-worker) benefit:			
Awarded	$81.26	$81.06	$80.60
In current-payment status, end of month	77.53	77.47	76.87
Number of disability insurance (disabled-worker) benefits:			
Awarded	17,582	15,959	15,716
In current-payment status, end of month	893,458	886,287	819,473
Average disability insurance (disabled-worker) benefit:			
Awarded	$94.96	$95.03	$94.85
In current-payment status, end of month	91.15	91.04	90.55
Number of persons aged 62 and over receiving monthly benefits, end of month (OASI and DI) 4/	15,489,000	15,440,000	14,882,000
Number of persons aged 65 and over receiving monthly benefits, end of month (OASI and DI) 4/	13,624,000	13,568,000	13,119,000
Assets of trust funds, end of month (in millions):			
OASI	$19,389	$19,149	$18,503
DI	2,157	2,152	2,305

1/ Exceeds monthly amount of benefits in current-payment status because initial payments include amounts payable for prior months. Distribution by type of monthly benefit estimated.
2/ Distribution by type of claim for OASI child's benefits estimated.
3/ Average lump-sum per worker; 69,985 deceased workers represented in the current month's lump-sum awards.
4/ Numbers estimated to the nearest thousand.

Source: Division of the Actuary, Social Security Administration.

AMOUNT EXPENDED PER INHABITANT 1/ FOR PUBLIC ASSISTANCE PAYMENTS INCLUDING MEDICAL CARE VENDOR PAYMENTS, FISCAL YEAR ENDED JUNE 30, 1964



1/ BASED ON POPULATION AS OF JULY 1, 1964 EXCLUDING ARMED FORCES OVERSEAS ESTIMATED BY THE CENSUS BUREAU, SERIES P-25, NO. 289

2/ AVERAGE FOR ALL STATES. FOR STATES MAKING MAA PAYMENTS THE AVERAGE IS $2.78. 3/ NO PROGRAM. 4/ LESS THAN $0.005. 5/ ESTIMATED 6/ INCOMPLETE. 7/ NOT REPORTED.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Welfare Administration
WASHINGTON, D. C. 20201

OFFICIAL BUSINESS

POSTAGE AND FEES PAID
U. S. DEPARTMENT OF H. E. W.

FEBRUARY
1965
Vol 3-No2

ROOM USE ONLY

BRUARY
1965
l 3-No 2